2000

Healthy Rhode Islanders Progress Review

Rhode Island Department of Health
Patricia A. Nolan, MD, MPH, Director
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Introduction

The setting of health objectives has become an important part of the public health improvement strategy over the last twenty years. It began in 1979 with the publication of HEALTHY PEOPLE, The Surgeon General's Report on Health Promotion and Disease Prevention, by the U.S. Department of Health, Education and Welfare. This groundbreaking plan laid out Health Goals and Objectives for 1990 in order to bring "management by objectives" to the public health process. This was followed in 1990 with the publication of HEALTHY PEOPLE 2000: National Health Promotion and Disease Prevention Objectives by the U.S. Department of Health and Human Services.

Like most States, Rhode Island followed by producing its own version of year 2000 health objectives in 1994 entitled HEALTHY RHODE ISLANDERS 2000 which contains 25 health objectives designed specifically for Rhode Island. The U.S. Department of Health and Human Services launched the third generation of national health objectives in 2000 with the adoption of HEALTHY PEOPLE 2010. Again, it is the intent of the Rhode Island Department of Health to follow the lead of the federal government. With our partners we intend to create Rhode Island health objectives for the year 2010 to guide our public health efforts over this first decade of the 21st century.

However, before we begin the new objective setting process, we believe it is important to take stock of our collective progress in meeting the 25 Rhode Island health objectives for the year 2000. There is no point in setting objectives for the year 2010 until we have a good idea of the progress made in meeting our health objectives for the year 2000 which is now here! Each cycle of health planning should end with an evaluation phase before the next iteration of setting objectives begins. That is the purpose of this report.

We hope that this PROGRESS REVIEW will provide a solid foundation for the creation of year 2010 health objectives for Rhode Island. We look forward to working with all of our collaborators on that next phase of this central public health planning process.

Patricia A. Nolan, M.D., M.P.H.
Director of Health

Healthy Rhode Islanders 2000 Progress Review

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Acknowledgments

The conduct of this important review required the cooperation and effort of many different individuals and groups. On behalf of the Department of Health, I want to express our thanks to all who helped to make this historic review possible. First and foremost, we wish to thank those individuals in the various divisions of the Department of Health who took responsibility for drafting, circulating and redrafting the 25 Health Objective Progress Reviews contained in this report. The names and divisional affiliations of these individuals are identified in Appendix A, Contributors 1.

Next we would like to thank the community advisory groups, organizations and individuals that reviewed and commented on each of the 25 Health Objective progress statements. These are listed in Appendix A, Contributors 2.

Finally, we wish to thank the core group in the Director's Office who made the completion of this document possible. These individuals and their respective roles are listed in Appendix A, Contributors 3. A special thanks to Richard Bolig, who produced the layout and design for the Healthy Rhode Islanders series. Richard is retiring from State service at the end of calendar year 2000.

Public health is by definition a collaborative process. The production of this Progress Review reflects the variety of program objectives, public health professionals, and diverse constituencies that makes up the richness of the public health enterprise.

William J. Waters, Jr., Ph.D.
Deputy Director

March 2001
Post Conference Edition

Executive Summary

for each Health Objective:

Why It's Important

What We Have Achieved

Key Collaborators

By the Numbers

Who to Contact

This document measures progress made in meeting the Rhode Island health objectives for the year 2000. This evaluation of progress has two aspects to it: statistical and programmatic. Given a substantial enough investment in effective programs, one would expect eventually to see measurable progress in the quantitative health objectives. This report assesses programmatic activities conducted by the Rhode Island Department of Health in conjunction with its partners to make progress in attaining the 25 Rhode Island health objectives for the year 2000. These assessments reflect programmatic activities ranging from fledgling programs to some well-established programs. This report also provides statistical indications of the progress that is being made in reaching the 25 Rhode Island health objectives for the year 2000 (See pp. vi and vii, and Appendix C, p. 103), as well as "2010 Notes" for each health objective, clues to the directions each program will take in looking ahead to the 2010 Health Objectives. A review of this statistical information indicates that progress is being made in some important health objectives such as Children's Blood Lead Levels (No. 12) and HIV Prevalence (No. 21), but that there is a lack of statistical progress, or slippage, in some other key health objectives such as Physical Activity (No. 1) and Nutrition (No. 2). Thus, much work remains to be done if the goals of HEALTHY PEOPLE at the national and state levels are to be met.

With respect to minority health, the Rhode Island Department of Health and the Minority Health Advisory Committee have collaborated over the last eight years to reduce health disparities between minority groups and whites in Rhode Island (p.10). Substantial progress has been made in terms of process measures. A network of community-based Minority Health Promotion Centers has been established in the various minority communities of the State, and the advisory committees and personnel of the Department of Health now reflect more diversity. Nevertheless, again, much remains to be done. As the minority health statistics in this report reflect, measurable progress is being made in some important areas such as infant mortality rates for Blacks, Asians, and Native Americans, but other key areas such as the prevalence of blood lead in Asian children have not changed or are worsening. The reduction and elimination of health disparities within minority populations will be a central part of the year 2010 health objectives process in Rhode Island.

It should be noted that the most recent data used to report progress on individual objectives range from 1996 to 1999 depending on availability. Thus, this is not the final word on the achievement of the Rhode Island Year 2000 Health Objectives.

Level of Improvement by Objective

Objective	Achieved/Exceeded Goal	Substantial Improvement	Some Improvement	Negative Direction	Insufficient Data
1 Physical activity				↓	
2 Nutrition			↑		
3 Tobacco use			↑		
4 Alcohol & drug related problems				↓	
5 Unintended pregnancies			↑		
6 Suicide & suicide attempts		↑↑			
7 Mental disorders					--
8 Homicides		↑↑			
9 School health education			↑		
10 Unintentional injuries			↑		
11 Work-related injuries		↑↑			
12 Children's blood/lead levels	↑↑↑				
13 Environmental tobacco smoke		↑↑			
14 Radon					--
15 Drinking water quality	↑↑↑				
16 Food borne pathogens	↑↑↑				
17 Oral health		↑↑			
18 Birth outcomes		↑↑			
19 Controlled high blood pressure					--
20 Breast & cervical cancer screening		↑↑			
21 HIV prevalence	↑↑↑				
22 Infectious diseases				↓	
23 Immunization		↑↑			
24 Primary care			↑		
25 Limitations of activity				↓	

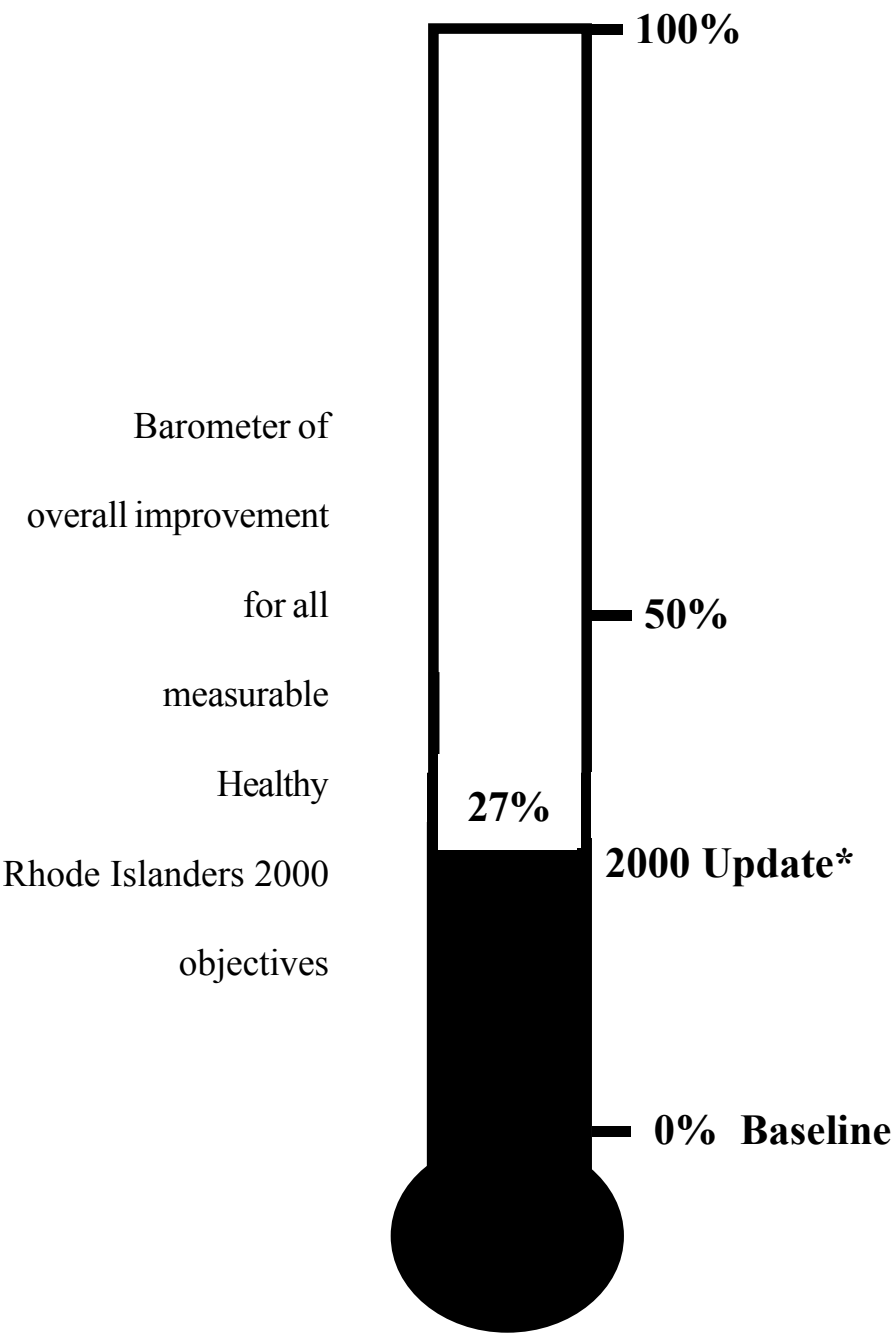
↑↑↑ = index of 100

↑↑ = index of 45 or higher but less than 100

↑ = index greater than 0 but less than 45

↓ = index of 0 or less

Progress Barometer



* The apparent lack of overall progress can be attributed primarily to backsliding in 4 of the 25 objectives (see page vi - Level of Improvement by Objective).

Goals of Healthy Rhode Islanders 2000

In reviewing progress made in the attainment of the 25 Rhode Island health objectives for the year 2000, it is important to remember and focus on the three overarching Goals that were established as part of the HEALTHY RHODE ISLANDERS 2000 process. These three Goals, which were adopted in 1994, are as follows:

- ✓ Increase the span of healthy life for all Rhode Islanders.
- ✓ Reduce health disparities among Rhode Islanders.
- ✓ Achieve access to preventive services for all Rhode Islanders.

Healthy Rhode Islanders 2000

Progress Review

Progress on Health Objectives

Progress

Health Disparities among Racial and Ethnic Groups

1. State of Rhode Island Minority Health Initiatives

Racial and ethnic minorities in Rhode Island, as in the rest of the nation, suffer disproportionately from poor health outcomes and premature mortality. The causes of poor health among minority populations are varied and include poor access to health care (inadequate health insurance and institutional barriers); unfavorable lifestyle factors such as smoking, alcohol consumption, inadequate diet and lack of exercise; and environmental factors, such as unsafe living/housing conditions and working environments. As a result of the myriad of factors that contribute to health status disparities, efforts to eliminate disparities must also be diverse, innovative and bold.

In the time period of 1990-2000, the State of Rhode Island undertook a proactive role in developing strategies and initiatives to address health status disparities and the underlying reasons for these unequal outcomes. Essentially, these strategies/initiatives can be classified into three broad categories: 1) addressing cross-cutting issues; 2) supporting community-based minority health promotion; and 3) prioritizing minority health in all Rhode Island Department of Health (HEALTH) planning and program implementation. Progress made in each of these categories is recorded below.

2. Cross-Cutting Issues

Cross Cutting Issues are those issues that have an impact on the overall health care system. With respect to eliminating racial and ethnic disparities, the U. S. Department of Health and Human Services has identified four cross-cutting issues: 1) cultural competency; 2) improving racial and ethnic health data; 3) increasing minority involvement in public health; and 4) increasing access to care. With regards to the issue of *cultural competency*, HEALTH has engaged a consulting firm, Judith Kaye Training and Consulting, Inc. to develop a skills-based cultural competency training curriculum for public health professionals. The rationale behind development of such a curriculum is that public health officials need to be prepared to work with individuals from across cultures in a culturally competent manner. In addition to providing training to its staff on cultural competence, HEALTH has shared a copy of this curriculum with health care providers throughout the State, and has placed the cultural fact sheets used in the training on the Department's web site to ensure wide dissemination of relevant materials and information.

Beginning in 1987, HEALTH began efforts to *improve the availability and reliability of data on racial and ethnic minority populations*. The first comprehensive set of minority health indices was prepared for inclusion in a study conducted by the Urban League of Rhode Island, entitled Assessing the State of Racial Minorities in Rhode Island, 1987. In December of 1990, Minority Male Health in Rhode Island: A Statistical Source Book was published. This sourcebook presented a selection of tables, which showed the gap between health expectations of minority and non-minority males. Also, in 1990 HEALTH

as a part of a capacity-building program for chronic disease prevention, began developing a Minority Lifestyle Survey, designed to provide a baseline assessment for health promoting behaviors among the state's Black and Hispanic populations. Other minority data reports published in the 1990-2000 time period include The Health of Minorities in Rhode Island, May 1993; Healthy Rhode Islanders 2000: Sourcebook for Minority Health, 1995; Priorities for Improving Minority Health Data, 1995; Minority Health Data Symposium Report, 1998.

To address the lack of data on Native Americans and Asian Americans, HEALTH produced the minority health fact sheets series. The fact sheet series contains data pertaining to each racial and ethnic minority group in the State of Rhode Island relating to population demographics, socio-economic status, leading causes of death, behavioral risk factors, rates of infectious disease, maternal and child health and access to care for each group. In 1997, the Minority Health Advisory Committee in collaboration with HEALTH held the first minority health data symposium in order to engage the community in a meaningful dialogue about racial and ethnic health data and to inform the community of the availability of different data sets. A second symposium was held in 1998 to discuss the President's Initiative on Race and Health and how Rhode Island fared with respect to eliminating disparities in the six target areas (breast cancer, diabetes, heart disease, HIV/AIDS, infant mortality and immunization). In addition, HEALTH in collaboration with community partners has developed a policy guide on the collection of race and ethnicity data. All HEALTH programs, and agencies funded and/or regulated by HEALTH will be required to comply with this policy guide in collecting and analyzing race/ethnicity data for public health purposes.

Minority participation in decision-making public health boards and commissions has increased in the ten-year period of 1990-2000. As a result of aggressive outreach, minorities serve on 23 of these boards and commissions, with the goal of having minority participation on all 32 of them.

Access to Care for racial and ethnic minorities in the State has been enhanced through the development of the RIte Care program. In the six-year period 1990-1996, there was an increase in access to care for all race/ethnicity categories as evidenced by an increase in routine physician visits and preventive dental visits. Additionally, with the development of the RIte Care Part A and B program in 1999, concentrated outreach is being conducted to reach all individuals who qualify for RIte Care, but are not enrolled. Many of the RIte Care Part A and Part B agencies are also Minority Health Promotion Centers (community-based centers that specialize in providing health information, education, health risk assessment, consumer empowerment and outreach to minority populations).

3. Supporting Community-Based Minority Health Promotion

In 1992, the state legislature passed the Minority Health Promotion Act (Article 102, Title 23, and Chapter 64). The Act called for the creation of a minority health promotion program "to provide health information, education, risk reduction activities in order to reduce the risk of premature death among minority populations from preventable conditions". Working with a Minority Health Advisory Committee, the Office of Minority Health awarded approximately 1.6 million dollars to community-based agencies in the time period 1994-2000. In 1998, agencies awarded grant funding through the Minority Health Promotion Program were asked to institutionalize their programming through the creation of Minority Health Promotion Centers. Minority Health Promotion Centers are responsible for six activities as listed below:

(1) Conducting individual and community health risk assessment activities;
(2) Conducting community outreach;
(3) Provision of health education regarding health conditions for which minorities are dying prematurely;

(4) Provision of consumer empowerment activities which educate consumers regarding their rights and responsibilities with regard to the health care system;
(5) Development of health information centers; and
(6) Working with health care providers to provide health screenings and referrals for health care.

Minority Health Promotion Centers are operated by community-based agencies with an established record of service to the minority community. In providing minority health promotion services, the Centers have established collaborative relationships with the following organizations: RIte Care, RI Department of Health Diabetes Multicultural Coalition, Women's Cancer Screening Program, Lifespan, Traveler's Aid Society, Providence Family Van, American Heart Association, American Lung Association, National Marrow Donor Program, RI Project AIDS, Providence Ambulatory Health Clinics, Providence Smiles, Neighborhood Health Plan, Ocean State Action Fund, Immigration and Refugee Services, Brown University. Specific accomplishments for some of these Centers are recorded below:

The *International Institute* provided health education to immigrants relating to cancer, diabetes, cardiovascular disease, and women's health. Approximately 500 immigrants from more than forty different countries are provided with these services. In addition to providing education on the aforementioned topics, the Institute also provided monthly Spanish language Immigration workshops to help immigrants understand the issue of public charge and its implications for accessing care. Immigrants participating in the program signed up for free mammograms, received flu shots and free screenings for cholesterol.

The *Providence Housing Authority's* award-winning health education program WISE-UP (Women and Infants Sex Education and Understanding Program) promotes healthy and wise decision-making with the goal of reducing rates of teen pregnancy. Since the beginning of the WISE-UP program in 1994, there have been no recorded pregnancies among WISE-UP participants. Integrated into the already successful after-school PHA Youth Program, the WISE-UP curriculum combines educational and interactive weekly workshops in a classroom setting with informal group discussion, guest speakers, role playing activities and occasional field trips. While WISE-UP educates teens, the Health PHASE program (Public Housing Adult & Senior Education) focuses on improving the health status of adults and teens. Health topics addressed through Health PHASE include diet, nutrition, exercise, stress and disease prevention and management.

The Socio-Economic Development Center for Southeast Asians (SEDC) provides health education and disease prevention programs for Rhode Island's Southeast Asian residents. The Center has increased access to care for Southeast Asians, and ensured access to health screenings and health information for this population as well. On an annual basis more than 150 Southeast Asians receive services and information through this program relating to cancer, cardiovascular disease, and diabetes. Additionally, more than 200 health care providers receive training on Southeast Asian culture and health practices through the provision of an annual conference on cultural competency.

The Neighborhood Minority Health Promotion Center (NMHPC) at *South Providence Neighborhood Ministries (SPNM)* has made a measurable contribution to reducing health status disparities among minorities and the general population through empowering neighbors with the information and advocacy that they need to access appropriate health care services and physical fitness programs. Activities of SPNM have included maintaining a Resource Center for health information, revising and distributing consumer-friendly information on RIte Care and Medicaid programs and the difference between primary care and emergency room services, providing health education workshops, providing on-site diagnostic

screening programs, providing referrals for health services, and providing staff advocacy and follow-up.

*The Urban League of Rhode Island Inc. (*ULRI), a community-based organization with a 60-year history of service to the African American and other minority communities in Rhode Island, has developed and implemented programs and initiatives to improve the health of minority youth, teen mothers and adults living in the Providence area. The Center provides education and screening programs to address infant mortality, unintentional injuries, chemical dependency and teen pregnancy for which minorities were experiencing a disproportionate burden. Through the Center's ongoing activities, the ULRI has improved access to health information, education resources and health screenings thereby increasing the comfort level of teen moms in communicating with their doctors and other health care professionals regarding their health care needs and concerns and to obtain appropriate health services when needed. Additionally, the ULRI has published a Minority Health Community Resource Guide.

The Providence Family Van provides confidential health risk assessments to 500 adolescents and adults annually with appropriate education, information and referrals on a variety of health topics including but not limited to: cancer, diabetes, cardiovascular disease, infant mortality, HIV/AIDS, family planning, STD's, access to care. In addition to providing health education, referrals and screening services, the Providence Family Van has assisted local residents to form neighborhood Task Forces designed to address barriers to care and community needs.

4. Minority Health and Healthy Rhode Islanders 2000

Minority Health has been identified as a priority issue in the State of Rhode Island, and as such it has received specialized attention within the activities associated with the twenty-five Healthy People 2000 Objectives identified through Rhode Island's Healthy People 2000 planning process. Special initiatives and targets for reducing health disparities among racial and ethnic minorities and non-minorities have been set in areas, such as HIV/AIDS, tobacco control, breast cancer screening, diabetes, physical fitness and numerous other areas. A majority of the Healthy People 2000 Progress Review statements provide data and information relative to minority health and the special initiatives/targets that have been set.

5. Measuring Health Disparities in Minority Populations

Articulating, and quantifying, the nature and extent of health disparities in racial and ethnic minority populations has been a public health challenge for many years. At the national level, measuring the impact of poor health on the quality and length of life for minority citizens was considered to be such an imperative that one of the three overarching goals of Healthy People 2000 was to reduce health disparities among the disadvantaged.[1] In Healthy People 2010, the goal has been made even more challenging; the nation is now committed to the elimination of such disparities entirely.[2]

Early in the last decade, the health disparities of minority populations in Rhode Island were documented in conjunction with the establishment of the aforementioned minority health program in the Rhode Island Department of Health.[3,4] Many of the measures used were those that had been selected to monitor progress toward the achievement of the statewide health objectives in *Healthy Rhode Islanders 2000*.[5] Recently, as the Department has been evaluating the state's level of success in achieving those objectives, we have also re-measured the extent of health disparities in our minority populations.

Following are the findings for four selected measures of health status for which minority populations have been historically disadvantaged and for three selected measures of health risk behavior. The

health status measures include infant mortality rates, homicide rates, tuberculosis incidence rates, and lead poisoning rates. The health risk measures are cigarette smoking, physical exercise, and preventive dental visits. These measures were defined as in *Healthy Rhode Islanders 2000*[5] and were computed for Rhode Island residents of each race and for residents of Hispanic origin (independent of race where possible). For most measures, multiple years of data were grouped to enhance statistical stability.

6. Health Status Measures

Infant mortality. Infant mortality rates were computed as deaths prior to one year of age divided by total live births during the periods 1989-1991 and 1995-1997. For many minority racial and ethnic groups, these rates have historically been elevated both in Rhode Island and nationally. During 1995-1997, rates in Rhode Island for Blacks, Native Americans, and Hispanics ranged between 31% and 127% higher than the statewide rate, while the rate for Asians was 27% below the state average. (Figure 1) Since 1989-91, infant mortality rates for Blacks (down 44%), Asians (down 38%), and Native Americans (down 18%) have fallen. The declines for Blacks and Asians have been greater than the decline in the statewide rate (down 27%). However, the rate for Hispanics has increased 31%. (Figure 2)

Figure 1. Average Annual Infant Mortality Rate, by Race and Ethnicity, Rhode Island, 1995-1997

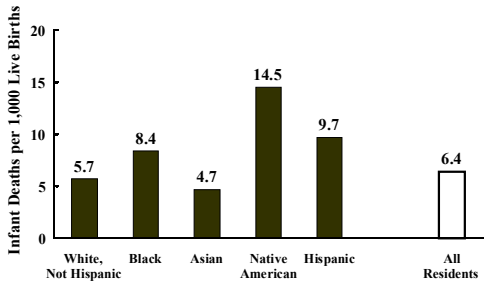
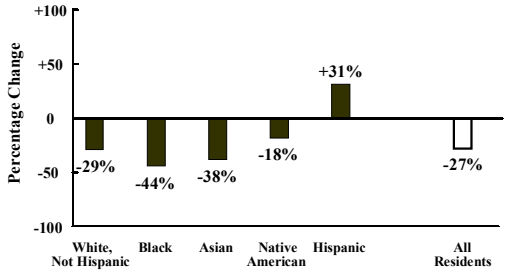


Figure 2. Percentage Change in Average Annual Infant Mortality Rate, by Race and Ethnicity, Rhode Island, 1989-91 to 1995-97



Homicide. Age-adjusted homicide rates were computed from the number of deaths with an underlying cause of death of homicide for the periods 1989-1991 and 1995-1997 and Rhode Island population estimates by age, race, and Hispanic origin for the same years,[6] using the 1940 United States population as standard. There were marked differences in homicide rates by race and Hispanic origin in Rhode Island during 1995-1997. Rates for Blacks, Native Americans, and Hispanics were higher than the statewide rate; rates for Asians and non-Hispanic Whites were lower. (Figure 3) The rate for Black Rhode Islanders was especially elevated, eight times as high as the statewide rate. Since the period 1989-91, the statewide homicide rate declined 33% in Rhode Island, but the decline for Black Rhode Islanders was

Figure 3. Average Annual Homicide Rate*, by Race and Ethnicity, Rhode Island, 1995-1997

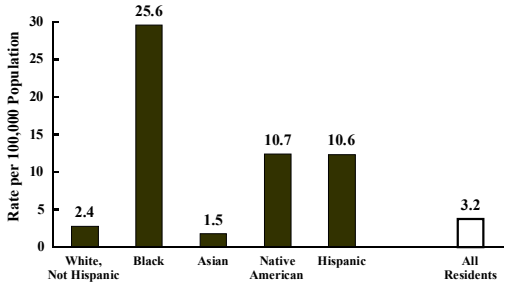
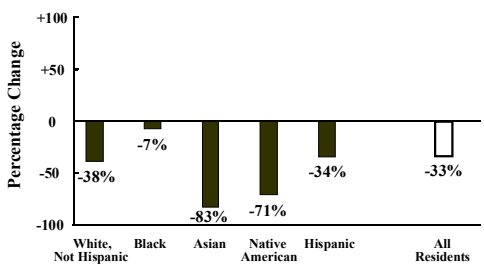


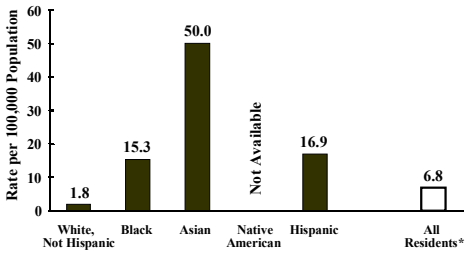
Figure 4. Percentage Change in Average Annual Homicide Rate*, by Race and Ethnicity, Rhode Island, 1989-91 to 1995-97



only 7%. (Figure 4) Declines for Asians (83%) and Native Americans (71%) were relatively large, and the decline for Hispanics (34%) was close to the state average.

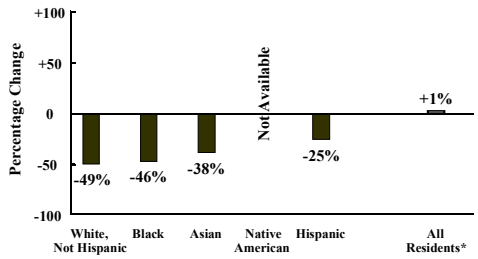
Tuberculosis. Incidence rates for tuberculosis were computed from the reported number of newly diagnosed cases of tuberculosis during the periods 1989-1992 and 1995-1998 and Rhode Island population estimates by race and Hispanic origin for the same years.[6] The disparities by race and ethnicity for tuberculosis incidence rates were among the greatest disparities seen among Rhode Island residents. The rate for Asians was nearly 30 times that for non-Hispanic Whites, and the rates for Blacks and Asians were also highly elevated. (Figure 5) Between 1989-1992 and 1995-1998, tuberculosis incidence rates for all race/ethnicity groups declined, except for Native Americans, among whom there were no cases reported during either period. (Figure 6) The largest percentage decline occurred among non-Hispanic Whites, but the declines among both Blacks and Asians were also greater than the percentage decline statewide (down 28%). However, the decline among Hispanics was smaller than the statewide decline.

Figure 5. Average Annual Incidence Rate for Tuberculosis, by Race and Ethnicity, Rhode Island, 1995-1998



* Includes persons for whom race and ethnicity were not reported.

Figure 6. Percentage Change in Average Annual Incidence Rate for Tuberculosis, by Race and Ethnicity, Rhode Island, 1989-92 to 1995-98



* Includes persons for whom race and ethnicity were not reported.

Lead exposure. Rates of lead exposure for children ages 6 years and younger were computed as the number of children with blood lead levels of 15 micrograms per deciliter divided by the number of children tested during 1998. Rates of elevated blood lead levels were higher for children in all minority populations during 1998, with the rate for Asian children nearly six times the statewide rate. (Figure 7) Compared to 1994 rates (the first year for which data by race and ethnicity are available), only the rate for Hispanics has decreased more rapidly (down 68%) than the statewide rate (down 65%). (Figure 8) Rates for Black and Native American children (down 49% and 22% respectively) have decreased less rapidly than average, and the rate for Asian children has increased 44%.

Figure 7. Prevalence of Blood Lead ≥ 15 Micrograms/dL, Ages 0 - 6 Years, by Race and Ethnicity, Rhode Island, 1998

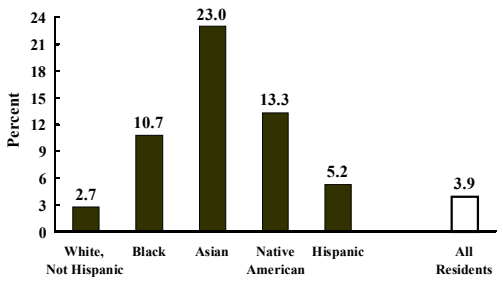
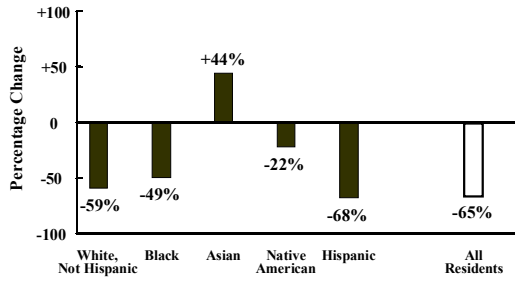


Figure 8. Percentage Change in Prevalence of Blood Lead ≥ 15 Micrograms/dL, Ages 0 - 6, by Race and Ethnicity, Rhode Island, 1994 to 1998



7. Health Risk Behavior Measures

Measures of health risk behavior were obtained from telephone surveys of samples of Rhode Island

residents performed at regular intervals by the Department of Health's Office of Health Statistics. Because of the small numbers of respondents involved, even with multiple years of data grouped, the health risk behavior measures for Asians and Native Americans are not reliable and therefore have not been reported.

Smoking. Cigarette smoking rates were computed for each race and ethnicity from the annual Behavioral Risk Factor Survey (BRFS) for the periods 1988-1992 and 1996-1998. Rates were based on the percentages of respondents ages 18 and older who reported being current cigarette smokers. Most recently, the smoking rate for Black Rhode Islanders was slightly higher than the statewide rate, and the Hispanic smoking rate was considerably lower. (Figure 9) Over time, the rate for Hispanics fell much more rapidly than the statewide rate, but the rate for Blacks fell more slowly. (Figure 10)

Figure 9. Rate of Current Smokers, Ages 18 and Older, by Race and Ethnicity, Rhode Island, 1996-1998

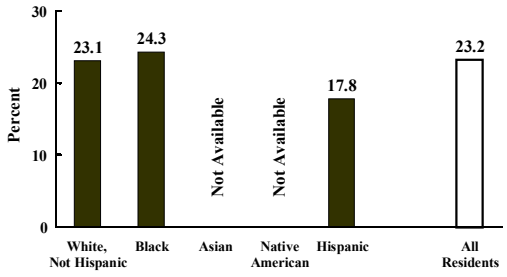
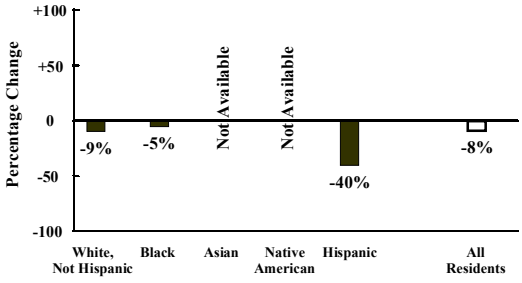
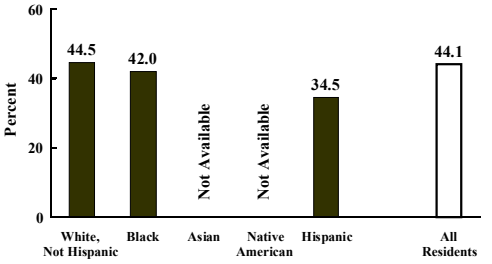


Figure 10. Percentage Change in Rate of Current Smokers, Ages 18 and Older, by Race and Ethnicity, Rhode Island, 1988-92 to 1996-98



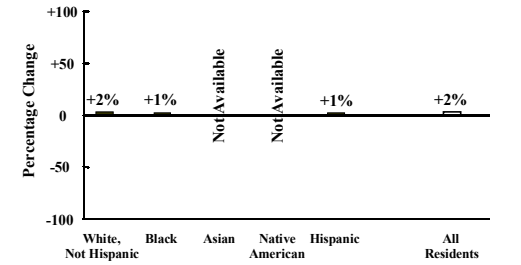
Physical exercise. Physical exercise rates were computed for each race and ethnicity from the BRFS for the period 1988-1992 and for the years 1996 and 1998 combined. Rates were based on the percentages of respondents ages 18 and older who reported exercising for at least three days per week for sessions of at least 20 minutes. Black and Hispanic adults reported being less likely to exercise adequately than was the case for all respondents. (Figure 11) Over time, there were small increases in exercise rates for all groups, but the increases for Blacks and Hispanics were slightly smaller than the increase for all state residents, i.e., in the direction of increasing disparity. (Figure 12)

Figure 11. Rate of Regular Exercise*, Ages 18 and Older, by Race and Ethnicity, Rhode Island, 1996 and 1998 Combined



* Exercising for 20 minutes or longer at least three days per week.

Figure 12. Percentage Change in Rate of Regular Exercise*, Ages 18 and Older, by Race and Ethnicity, Rhode Island, 1988-92 to 1996 &1998



* Exercising for 20 minutes or longer at least three days per week.

Preventive dental care. The percentages of persons ages 2 and older who had had a preventive dental visit in the past twelve months was obtained for each race and ethnicity from the 1990 and 1996 Rhode Island Health Interview Surveys, the two most recently completed such surveys.[7] Both Blacks and Hispanics were less likely to have received such care than the average resident, with the rate for Blacks being especially low. (Figure 13) However, both groups improved greatly in this measure between 1990 and 1996, in each case reducing the observed disparity substantially. (Figure 14)

8. Progress in Reducing Disparities

Infant mortality rates, homicide rates, tuberculosis incidence rates, and rates of excess blood lead levels are all specific health indicators that reflect adverse factors impacting health more broadly, such as poor access to prenatal care, high rates of non-fatal violence, poor housing conditions, and poverty. These health conditions and associated factors are among those that determine the lifelong health status and overall quality of life of a community's members. It is an accomplishment of some note that the statewide rates for all of these four conditions have fallen by between 27% and 65% in a period of less than a decade in our state. These improvements represent good progress toward the objectives of *Healthy Rhode Islanders 2000*.

Figure 13. Percent with Preventive Dental Visit in Past 12 Months, Ages 2 and Older, by Race and Ethnicity, Rhode Island, 1996

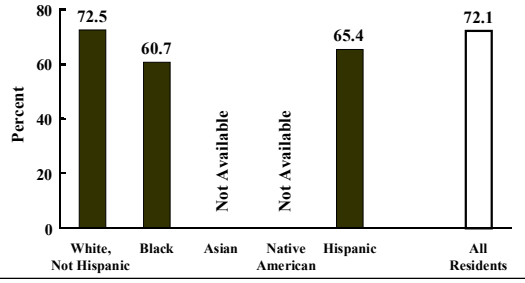
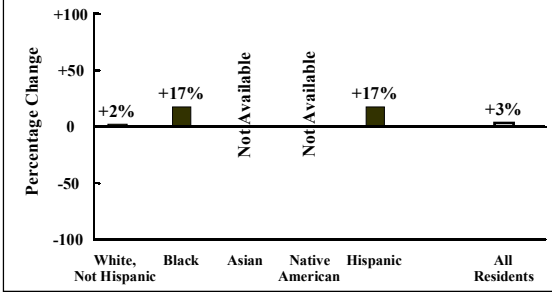


Figure 14. Percentage Change in Percent with Preventive Dental Visit in Past 12 Months, Ages 2+, by Race and Ethnicity, Rhode Island, 1990 to 1996



Similarly, the selected measures of health risk behavior are representative of major health promotion strategies: avoidance of health-harming behaviors, positive adoption of beneficial behaviors, and utilization of preventive medical services. Again, for all of these measures, there has been general improvement over the time periods chosen for comparison - fewer Rhode Islanders are smoking, slightly more are exercising, and more have had a preventive dental visit in the past twelve months.

However, progress has not been uniform across all racial and ethnic groups. For each of the indicators examined, there is at least one racial and ethnic minority population that has experienced an increasing disparity when current data are compared with the baseline data. For all measures taken together, there have been more instances of increasing disparity than of decreasing disparity.

Thus, progress in reducing disparities in these critical health indicators over the past decade in Rhode Island has been mixed despite the excellent improvements statewide. Put in this context, the Healthy People 2010 goal of eliminating health disparities must be viewed as a formidable challenge for our state's public health community.

References

[1]Public Health Service. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: U.S. Department of Health and Human Services. 1990.

[2]Internet: www.health.gov/healthypeople.

[3]Hesser JE, Buechner JS. *The Health of Minorities in Rhode Island*. Providence RI: Rhode Island Department of Health. 1993.

[4]Reynes JF, Buechner JS. *Healthy Rhode Islanders 2000: Sourcebook for Minority Health Status*. Providence, RI: Rhode Island Department of Health. 1995.

[5]Rhode Island Department of Health. *Healthy Rhode Islanders 2000*. Providence, RI. 1994.

[6]Internet: www.census.gov/population/www/estimates/statepop.html

[7]Kim HE, Hesser JE, Buechner JS. *Health Status, Behavioral Health Risks, Health Care Access, and Health Care Utilization among Rhode Islanders, 1990 and 1996*. Providence, RI: Rhode Island Department of Health. 2000.

Progress

Objective 1
Physical Activity

Increase physical activity by:

- Increasing to 60% the proportion of people aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day;
- Reducing to 15% the proportion of people aged six and older who engage in no leisure-time physical activity.

Lack of physical activity contributes significantly to chronic disease and disability in the United States and is associated with more than 250,000 deaths annually.

Why It's Important

The 1996 Surgeon General's report, *Physical Activity and Health*, states that people who are usually inactive can improve their health and well-being by becoming even moderately active on a regular basis. Physical activity need not be strenuous to achieve health benefits. Greater health benefits can be achieved by increasing the amount (duration, frequency, or intensity) of physical activity. Regular physical activity improves health by: reducing the chances of premature death, heart disease, diabetes, high blood pressure, colon cancer, depression/anxiety, and falls among older adults. Physical activity promotes: weight control, healthy bones/ muscles/ joints, and psychological well-being.

What We Have Achieved

The Rhode Island Prevention Coalition was formed in 1995 as a direct outgrowth of the establishment of Year 2000 Health Objectives in Rhode Island. The Prevention Coalition was initiated by the Rhode Island Department of Health and the founding members included the state's leading health plans, hospitals, and voluntary health organizations. After conducting a careful priority-setting process, the Prevention Coalition selected physical activity as its first priority for intervention. To date the Coalition has raised over $500,000 and has allocated over $330,000 of those funds for the promotion of physical activity at the local level through two RFP cycles. The first RFP cycle funded 15 local programs promoting physical activity amongst youth, elderly, minorities, the disabled and the general public. The second RFP cycle funded 7 programs to modify the physical and social environment to strengthen local resources for physical activity. These programs

include the establishment of multiple walking trails, exercise classes and walking clubs. The Prevention Coalition's latest initiative is to import the Irish Heart Association "Sli' na Slainte" (Path to Health) program into Rhode Island. The "Sli" objective is to establish and promote signed walking paths throughout Rhode Island. To date, two paths have been opened in Providence.

2010 Notes

Enhanced surveillance to determine non-leisure time physical activity, and "readiness" of people to participate in physical activity will strengthen the statewide efforts. Additionally, efforts must be aimed at partnering with schools, parent-teacher organizations, city/town planners, pedestrian safety advocates and other partners to increase physical activity levels among all Rhode Islanders. Efforts must focus on environmental changes including but not limited to increasing pedestrian access to allow walking short distances in communities, provision of worksite fitness programs and facilities and an increase in time for physical activity during the school day.

Other Efforts Include:

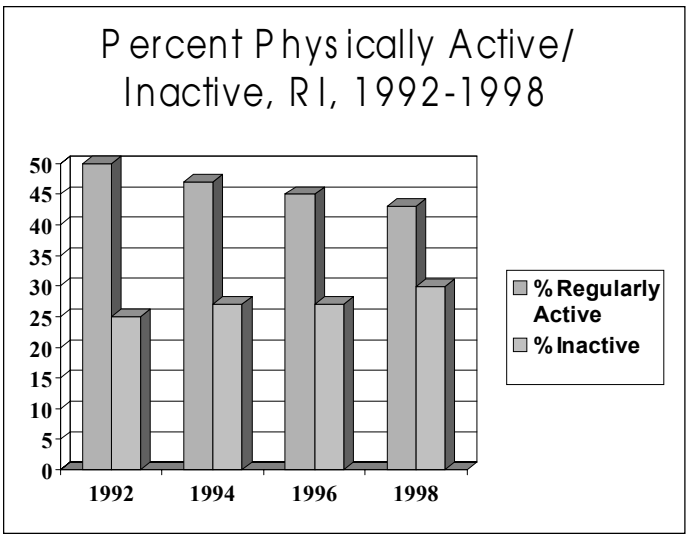
- A training workshop held for Child Opportunity Zone (COZ) Coordinators to increase their knowledge and access to resources in planning and implementing recreation and fitness programs targeted to family units.
- Training 11 low-income women as aerobics instructors as part of a pilot program, funded by the U.S. Region One Office of Women's Health; to date three of the women have taught aerobics classes.
- HEALTH physical activity coordinator was placed on the board of the RI Association of Health, Physical Education, Recreation and Dance as liaison for physical activity and Healthy Schools! Healthy Kids! Comprehensive School Health initiative.
- Collaboration with the American Heart Association/NE Affiliate, RI Chapter on the Physical Activity Resource Guide of Rhode Island.
- Presentation of an abstract and poster session on the RI Prevention Coalition at the 13th National Conference on Chronic Disease Prevention and Control sponsored by the Centers for Disease Control and Prevention, Atlanta, Georgia.
- Participation in the Centers for Disease Control and Prevention (CDC) AIM 30 Physical Activity Institute, 1997, 1999, 2000.

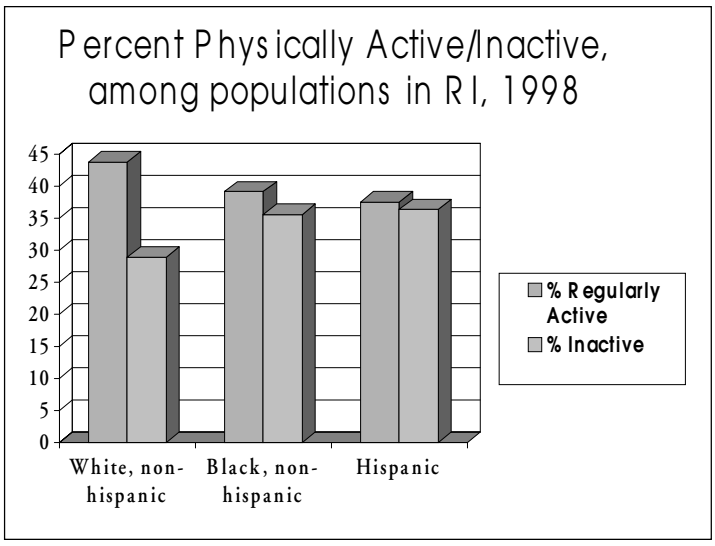
Key Collaborators

>Health Plans > Insurance Companies >Hospitals >Voluntary Health Agencies >Colleges & Universities >City & Town Parks and Recreation > RI Department of Transportation >YMCA and YWCA networks >Community-based organizations >Senior-service agencies

By the Numbers

The proportion of Rhode Island adults who are regularly physically active (20+ minutes a day, 3+ times per week) has decreased, and those who participate in no leisure time activity has increased, with the 1998 Behaviorial Risk Factor Surveillance System (BRFSS) showing 43.1% of the adult population in RI engaged in regular physical activity, and 29.9% reported as physically inactive. The 1998 figures also show a difference among racial and ethnic populations in RI, with higher levels of inactivity among minorities (see chart). The Surgeon General's Report recommends 30 minutes of moderate physical activity on most, preferably all days of the week. As of the 1998 BRFSS, 20.4% of the adult population are active at this level.





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Progress

Objective 2

Nutrition

Increase healthy diet by:

- Reducing dietary fat intake to 30% of calories or less and saturated fat intake to less than 10% of calories;
- Increasing complex carbohydrate and fiber-containing foods in the adult diet to 5 or more daily servings of vegetables and fruits, and to 6 or more daily servings of grain products;
- Reducing the mean serum cholesterol concentration among adults.

Why It's Important

These diseases and conditions are major causes of death and disability and can significantly reduce the quality of a person's life.

Diet is associated with five of the ten leading causes of death in the United States.

A diet high in fat, saturated fat, cholesterol, and sodium, and low in fiber and calcium, is associated with a variety of chronic conditions and diseases. These include cardiovascular heart disease, some types of cancer, adult diabetes, stroke, high blood pressure, high blood cholesterol, obesity, and osteoporosis. These diseases and conditions are major causes of death and disability and can significantly reduce the quality of a person's life.

Selected results from the USDA's 1994-96 "Continuing Survey of Food Intakes by Individuals" showed that fat accounted for 33 percent of calories in the American diet. This represents a continued decrease from 34 percent in 1989-91 and 40 percent in 1977-78. Despite this decrease, in 1994-96 only about one-third of adults met the 30 percent or less of calories from fat recommended by nutrition experts.[1] More Americans are obese than ever before.

The 1991 5-A-Day Baseline Survey reported that Americans ate only 3.5 of the 5 or more recommended daily servings of fruits and vegetables per day.[2] In 1998 in Rhode Island only 25% of adults reported eating at least 5 servings of fruits and vegetables per day, and 29% were overweight based on a body mass index of > 27.8 kg/m^2 for men and > 27.3 kg/m^2 for women (Behavioral Risk Factor Surveillance System, Rhode Island Statewide Survey Data, 1998).

What We Have Achieved

The Nutrition Advisory Forum of Rhode Island, formed by the Department of

Health in 1995, developed a statewide strategic Nutrition Plan in 1997.
The Nutrition Advisory Forum included 75 individuals from public and private agencies, organizations, and businesses that can affect the diet of Rhode Islanders directly or indirectly. The Forum assisted the Department in developing a Nutrition Strategic Plan for Rhode Island which guides the coordination of activities to improve the dietary behavior of all Rhode Islanders.

Other Efforts Include:

- Developed a statewide strategic Nutrition Plan distributed in 1997 (Nancy Beauchene, MS, RD).
- Coordinated the formation of the RI 5-A-Day Coalition to serve as a forum for state agencies, supermarkets, schools, restaurants, worksites, community health centers, community groups, and media representatives to share information, to foster collaboration, and to plan and evaluate state and local 5-A-Day activities.
- Obtained extensive media coverage of the RI 5-A-Day for Better Health Program by distributing feature articles to newspapers and community newsletters, and preparing an official 5-A-Day recipe with Johnson & Wales University Chef Frank Terranova on the RI Channel 10 "Cooking with Class" TV show during prime time news.
- Submitted a 1999 5-A-Day grant application to the National Cancer Institute to evaluate community-based 5-A-Day promotion programs as a channel for increasing the dietary intake of fresh fruits and vegetables, and utilization of the Farmer's Market Nutrition Program, by low-income participants in the RI WIC Program.
- Coordinated the formation of a statewide Osteoporosis Education and Awareness Program to serve as a forum to share information on statewide outreach projects and services to reduce osteoporosis in Rhode Island, and to foster collaboration between state and community agencies.
- Instituted a calcium intake module on the 2000 BRFSS.
- Co-coordinated the formation of a work group through the RI *Healthy Schools! Healthy Kids!* Comprehensive School Health Program to facilitate the establishment of school and family nutrition advisory councils at the local level and to improve the school cafeteria environment to promote healthy eating habits in a stress-free environment.
- Worked with the Department of Education to increase the number of schools that provide nutrition education from preschool through 12th grade through the distribution of 5-A-Day and other nutrition materials to be used in the classroom and cafeteria.
- Served on the Kids First Steering Committee (the advisory board of the Team Nutrition Training Institute), responsible for the oversight and coordination of Team Nutrition and other nutrition programs available to the RI school departments, and to families and children at nutritional risk.
- Analyzed and co-edited recipes submitted by members of Rhode Island's Southeast Asian Economic Development Center for the cookbook, "*A Taste of Southeast Asia*," in collaboration with the Department of Health's Office of Minority Health.

2010 Notes

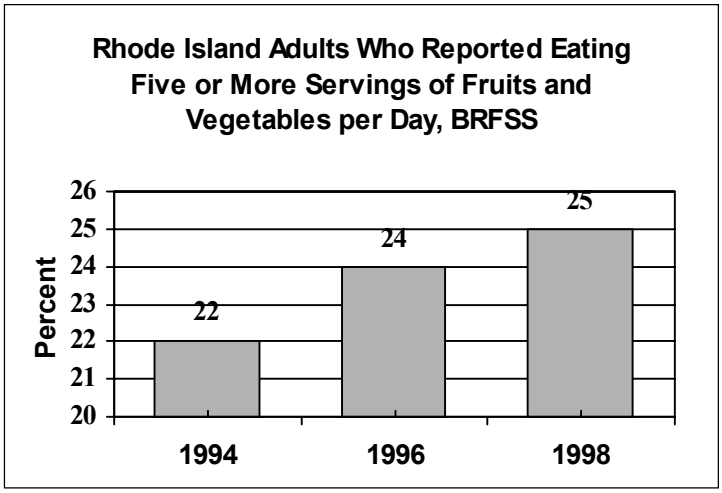
Utilizing the Nutrition Strategic Plan for Rhode Island as a guide, continue to improve on the efficiency and effectiveness of the delivery of nutrition programs through statewide coordination, communication and collaboration with statewide partners.

- Assisted with the planning, coordination, and evaluation of a Multicultural Health Fair at the University of Rhode Island's Multicultural Center during National 5-A-Day Week 1999.

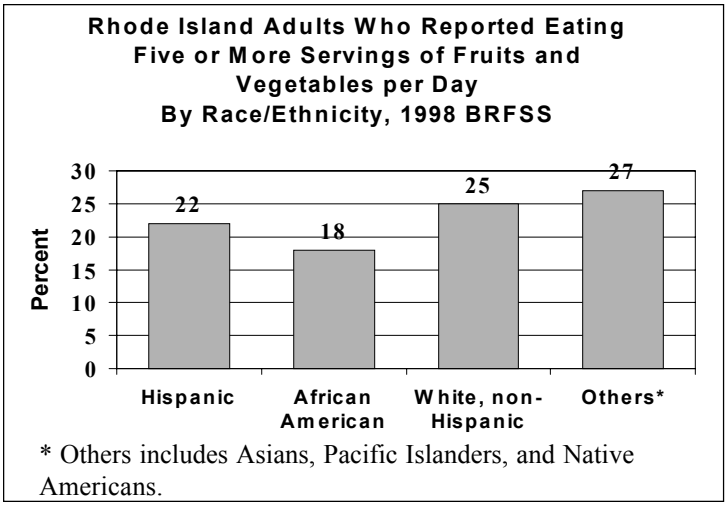
Key Collaborators

>Kids First (USDA Team Nutrition Program) >Public and private schools >RI Department for Children, Youth, and Families >RI Department of Education >RI Nutrition Hotline and Information Center >RI WIC Program >School food service vendors >Johnson & Wales University >Memorial Hospital of RI >Miriam Hospital of RI >New England Dairy & Food Council >Nutrition Advisory Forum >Rhode Island Hospital >University of Rhode Island >Women and Infants Hospital

By the Numbers



The proportion of Rhode Islanders consuming five or more servings of fruits and vegetables per day has increased between 1994 and 1998.



* Others includes Asians, Pacific Islanders, and Native Americans.

The African American population is less likely to consume five or more servings of fruits and vegetables than any other race/ethnic population in Rhode Island.

For More Information Contact

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Progress

Objective 3

Tobacco Use

Reduce tobacco exposure by:

- Reducing cigarette smoking to a prevalence of no more than 15% among people aged 20 and over;
- Reducing the initiation of smoking by children and youth, so that no more than 15% have become regular cigarette smokers by age 20;
- Reducing smokeless tobacco use by males aged 12 to 24 to a prevalence of not more than 0.5%.
- Prohibiting smoking in all restaurants.

Tobacco is the leading cause of preventable disease and death in Rhode Island and in the United States.

Why It's Important

Although cigarette smoking among adults in Rhode Island is declining, it has increased among adolescents. More than 25% of high school seniors now smoke. Since the likelihood of an individual starting to smoke after age 19 is negligible, preventing youth access to tobacco is a powerful tool in decreasing overall smoking rates. Yet in Rhode Island, teenagers go unchallenged more than 25% of the time when they buy a pack of cigarettes, even though it is against the law to sell tobacco to anyone under 18 years of age.

The evidence is overwhelming: Tobacco is harmful, highly addictive, and aggressively marketed to our children. The tobacco industry spends over $6 billion annually to promote its products, and $19 million annually on advertising in Rhode Island. And, although TV advertising has been banned since 1971, cigarette billboards and logos are seen in sporting events that are continually televised. Promotions offering free clothing and merchandise in exchange for "proof of tobacco purchase" entice youth. This makes it essential that adults become involved in helping protect our children from this multi-million dollar temptation.

What We Have Achieved

- Implemented a comprehensive program to address tobacco control through legislation, education, media advocacy, surveillance and evaluation.
- Effected restricted smoking policies in public places in 15 out of 39 municipalities.
- Trained community-based organizations to advocate for effective tobacco con-

trol policies/regulations.

- Increased the number of smokefree worksites, restaurants, beauty/barber shops, and laundromats.
- Educated all tobacco vendors about the FDA ruling and conducted compliance checks.
- Helped pass state legislation restricting tobacco use in schools, public places, and work sites, and restricting sales through vending machines.
- Persuaded seven pharmacies to stop selling tobacco and 31 pharmacies to place all tobacco behind the counter.

Other Efforts Include:

- Developing and implementing counter-marketing messages and other media efforts to focus public attention on issues regarding children's access to tobacco and clean indoor air and to decrease the appeal of smoking.
- Eliminating environmental tobacco smoke in public places and in homes where there are children under 18 years of age.
- Preventing initiation of tobacco use among children under 18 years of age.
- Promoting quitting among adults and children under 18 years of age.
- Identifying and eliminating disparities among population groups.
- Eliminating the sale, distribution, promotion of, and demand for tobacco products by those under the age of 18.
- Eliminating exposure of nonsmoking Rhode Islanders to second hand smoke, especially children under the age of 18 to reduce asthma triggers and other health problems.
- Increasing the number of people who quit smoking.
- Partnering with community organizations statewide to build and maintain policy and media advocacy networks.
- Assuring multiculturalism in all networks and engaging racial/ethnic minorities, especially children to take a leadership role in tobacco control advocacy.
- Adopting and enforcing municipal and organizational policies that mandate clean indoor air, restrict access to tobacco products by children, and restrict advertising and promotion of tobacco with increased public support.
- Increasing tobacco-free youth sports networks.
- Assuring enforcement of the smokefree schools law.
- Promoting school and population-based tobacco cessation programs.
- Assuring adoption and maintenance of effective school-based tobacco control curricula.
- Increasing adoption of smokefree workplaces and assuring enforcement of the law protecting the atmospheric environment of workers in all workplaces.
- Increasing routine smoking cessation advice by health care providers.
- Increasing cessation counseling by pharmacists and eliminating the sale of tobacco products by pharmacies.

2010 Notes

Using the Statewide Tobacco Control Plan as a tool to guide and to continue to improve on the efficiency and effectiveness of the delivery of tobacco control and prevention programs through statewide coordination, communication, advocacy efforts and collaboration with community-based and statewide partners.

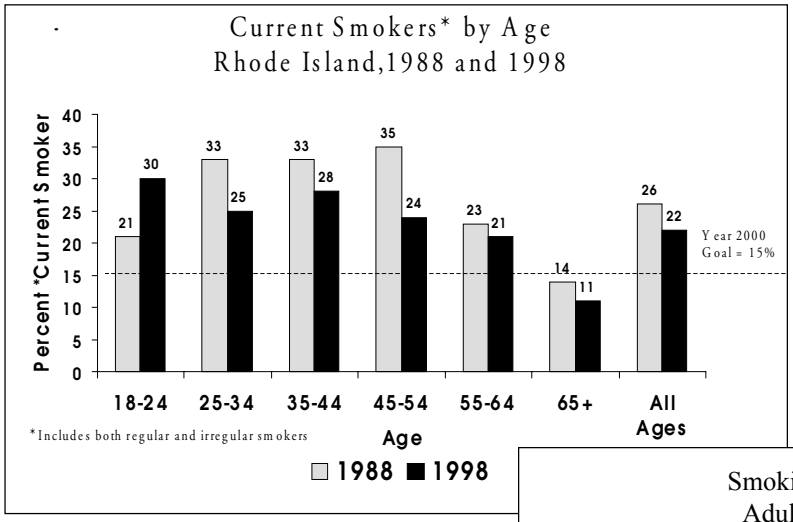
- Providing training and technical assistance to organizations engaged in tobacco control and prevention programs.
- Supporting the statewide Tobacco Control Coalition to plan and carry out tobacco prevention initiatives.

Key Collaborators

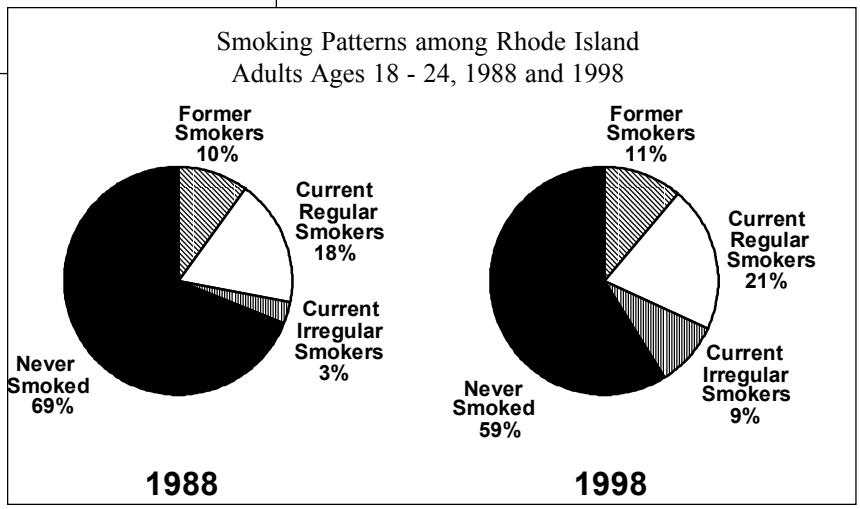
>Rhode Island Tobacco Control Coalition >American Cancer Society, RI Affiliate >American Lung Association, RI Affiliate >American Heart Association, RI Affiliate >Substance Abuse Prevention Task Forces >Urban League of Rhode Island >RI Pharmacy Foundation >March of Dimes of Rhode Island >RI Department of Education >RI Dental Association >RI Parks and Recreation Association >American Academy of Pediatrics, RI Chapter >RI Indian Council >Progresso Latino >Initiatives for Human Development >Mayor's Council on Drug and Alcohol Abuse >RI Council on Alcoholism and Other Drug Dependence >The Carriage House >Socio-Economic Development Center for Southeast Asians >Rhode Island Cancer Council >University of Rhode Island, Cancer Prevention Center >Rhode Island Hospital >Roger Williams Hospital >RI Parent Teacher Association >Miriam Hospital >Veteran's Medical Center >N.A.A.C.P.

By the Numbers

These data indicate clearly that the tobacco industry has been successful over the past decade in recruiting new smokers among young people. The increased smoking prevalence among young adults has partially offset the successes of smoking cessation campaigns and programs among adults ages 25 and older. Further reductions in adult smoking prevalence will require increased efforts to prevent smoking initiation among adolescents and young adults, as well as smoking cessation efforts to help heavier smokers quit.



These charts compare patterns of cigarette use among Rhode Island adults in 1998 with use patterns in 1988 based on data from Rhode Island's annual Behavioral Risk Factor Surveillance System (BRFSS).



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Progress

Objective 4

Alcohol and Other Drug-Related Deaths

Reduce alcohol and other drug-related deaths by:

- Reducing drug-related deaths by 21% to no more than 4.6 per 100,000 people (Baseline: 5.8/100,000; 1988);
- Reducing deaths caused by alcohol-related motor vehicle crashes by at least 20% to 4.5 per 100,000 people (Baseline: 5.6/100,000; 1985-90 average).

Analysis of the most recently available data indicates that Rhode Island has one of the most severe alcohol and drug abuse problems in the country.

Why It's Important

In the period 1991-1993, Rhode Island ranked fifth worst in the nation on an index of drug-related deaths, arrests, and treatment clients. A synthetic estimate study conducted by the Rand Corporation found that Rhode Island's drug dependence rate was in the upper third of states, Rhode Island having one of the highest rates among East Coast states. (National Technical Center for Substance Abuse Needs Assessment (NTC), North Charles Research, an Interstate Substance Abuse Indicator Chartbook, 1999.) However, the drug-related mortality rate in Rhode Island declined by 11% between 1988 (the baseline year) and 1997, from 5.8/100,000 to 5.2/100,000.

When compared to other states, Rhode Island's alcohol problems appear to be relatively less severe. In 1991-93 Rhode Island ranked 32nd most severe on an index of alcohol-related deaths, arrests, and treatment clients (NTC). 1999 estimates of rates of adult drinking place Rhode Island 23rd for binge drinking (5 or more drinks on one or more occasions in the past month), 12th for chronic drinking (60 or more drinks in the past month), and 21st for drinking and driving. Rhode Island's drunk driving arrest rate in 1991 to 1993 was the lowest in the country, and its alcohol-related automobile accident fatalities rank was 46th lowest in 1993 and 48th lowest in 1996.

Deaths due to alcohol-related motor vehicle crashes declined by 41%, from 5.6/100,000 (the average for 1985-90) to 3.3/100,000 in 1996. However, mortality rates for deaths where alcohol is explicitly mentioned rose 23% between 1991-93 and 1996, from 13/100,000 to 16/100,000.

What We Have Achieved

Rhode Island's rankings for alcohol-related motor vehicle deaths, and drunk driving arrests, may be attributed in part to the efforts of the Governor's Office on Highway Safety, which successfully implemented a statewide traffic safety coalition to raise awareness to issues such as drunk driving. A Legislative Issues Survey conducted by the coalition, revealed that 77.8% of the public favored reducing the Blood Alcohol Level (BAC) to .08. This figure was an increase of 16.8% from 1998. In the 2000 legislative session, the General Assembly passed the .08 BAC, a measure which the Governor then signed into law.

2010 Notes

The results from the completed "State Demand and Needs Assessment Studies: Alcohol and Other Drugs" will determine whether current substance abuse treatment services are adequate, accessible and appropriate.

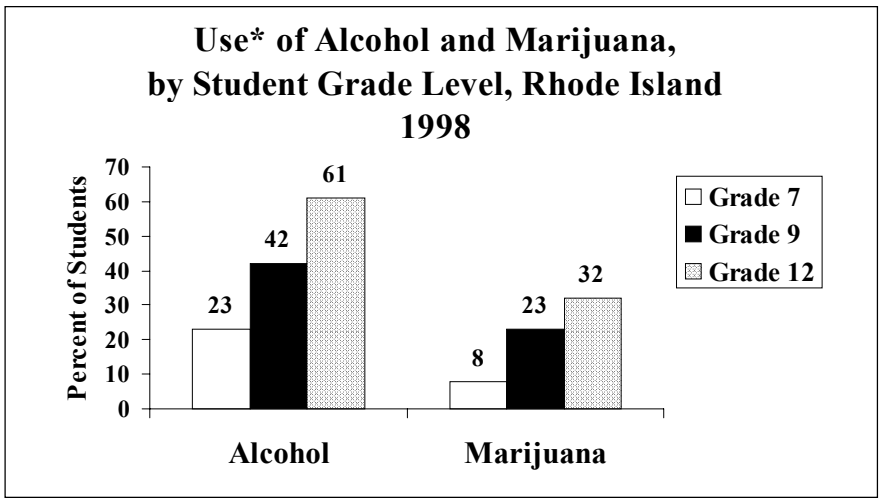
The states' significant drug problems are being addressed through the commitment of the Department of Mental Health, Retardation and Hospitals, Division of Substance Abuse, to expand treatment services to high risk populations. A Capacity Expansion Grant was awarded to augment treatment services to women in the Northern and Central/ Southern regions of the state. Additionally, residential treatment for racial and ethnic minority men, as well as for outpatient and methadone maintenance services for minority men and women, was also expanded.

The Department has increased its prevention services to include environmental strategies to reduce youth access to alcohol and to coordinate statewide efforts to enforce underage drinking laws.

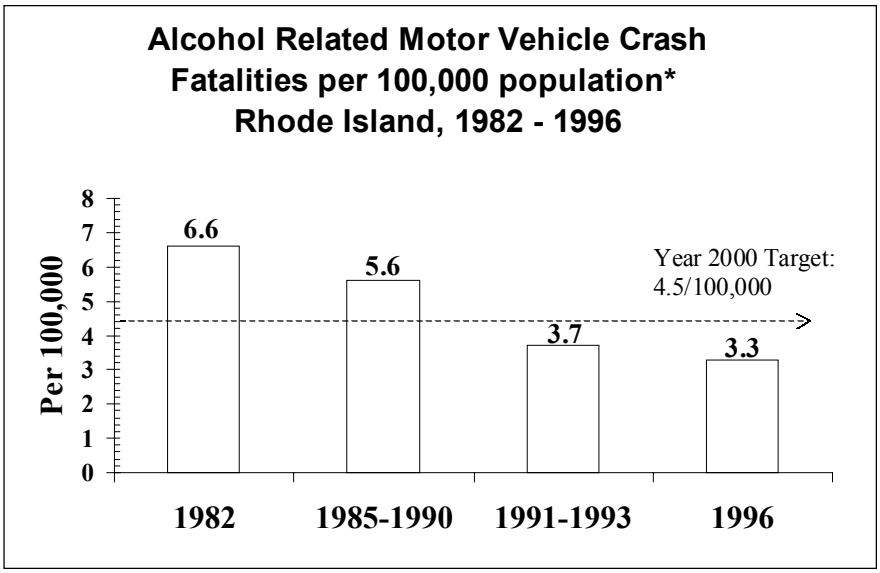
Key Collaborators

>Governor's Office on Highway Safety >North Charles Research and Planning Group >Drug & Alcohol Treatment Association >RI Cares >Council of Mental Health Centers >State Agencies >Municipal Police Departments and Task Forces >Mothers Against Drunk Drivers >Centers for Substance Abuse Prevention and Treatment >Office of National Control Policy >Brown University Center for Alcohol and Addictions Studies >University of Rhode Island

By the Numbers



*Student has used alcohol or marijuana in the past month. Based on a survey of 5,644 students in 7th grade, 4,350 students in 9th grade, and 2,401 students in 12th grade.
Source: 1998 RI Adolescent Substance Abuse Inventory



*Age-adjusted to 1940 US population

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Progress

Objective 5

Unintended Pregnancies

Reduce unintended pregnancies by:

- Reducing the proportion of pregnancies that are unintended by 30%, from 36% in 1990 to 25% 2000.

Unintended pregnancies have a negative impact on the health and well-being of all Rhode Islanders.

Why It's Important

In the United States, 9 in 10 women who are fertile, sexually active, and do not wish to become pregnant report that they use a contraceptive method. Yet, about half of the 6 million pregnancies in the United States annually are unplanned. Among minority populations, the percentage of unintended pregnancies is even higher. Among adolescents, 8 in 10 pregnancies are unintended. In the United States, on average, a woman has 2.1 children during her lifetime. As long as Americans continue to want small families, the need for contraception will remain great. A woman who is sexually active throughout her reproductive years and only wants two children will need contraception for more than twenty years of her life.

Unintended Pregnancies are a major factor contributing to poor pregnancy outcomes, poor child development, poor women's health, and to educational and economic disadvantage for both parents. Unintended pregnancies are associated with school failure, single parenthood, lost opportunities, late entry into prenatal care, and low birthweight. Numerous studies of child development, adolescent success, and women's health have emphasized the importance of preventing pregnancies that occur too early, too close together, and at other inappropriate times.

What We Have Achieved

The Rhode Island Department of Health (HEALTH), using federal Title X family planning funds and state family life funds, supports eleven local health agencies throughout the state to provide confidential family planning services, at no and reduced cost, to low income men, women and adolescents. These agencies also accept RIte Care and private health insurance reimbursement. The agencies serve

about 12,000 patients each year. The overwhelming majority are female (97%), and many represent minority groups (42%). Of the total number of patients served, 47% are uninsured for health care. Among other things, the agencies provide pregnancy prevention intervention for teenagers with negative pregnancy test results.

2010 Notes

1998 Provisional Data will be available during the year 2000.

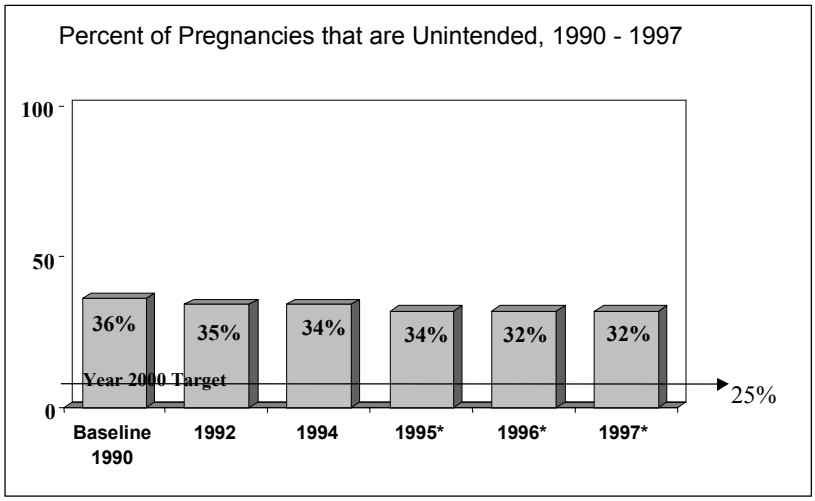
HEALTH, in partnership with the state Department of Human Services, administers a program that pays for vasectomies for uninsured and under-insured Rhode Island men. Uninsured and under-insured men often find the cost of a vasectomy to be a significant barrier. Interested men can receive services through any one of the thirteen private physicians participating in the program.

HEALTH, in partnership with the state Departments of Human Services; Education; and Children, Youth & Families developed a comprehensive statewide teen pregnancy prevention plan, which focuses on youth development through enhancing systems and supports that help parents and communities (including schools) address the developmental needs crucial to their children's success.

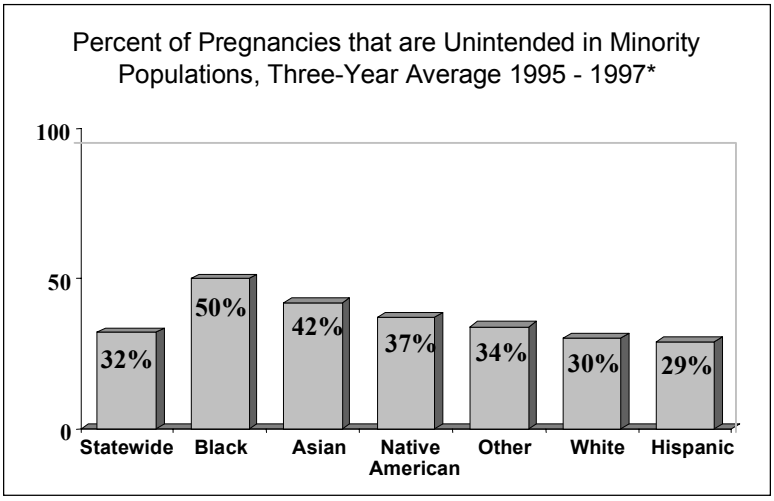
Key Collaborators

>Funded Health Care Agencies >Health Plans >State Agencies >Schools >Private Physicians > Community-Based Organizations

By the Numbers



The proportion of pregnancies that are unintended in Rhode Island has decreased between 1990 and 1996. However, the target to reduce unintended pregnancies by 30% has not been achieved.



Minority women are especially at risk for unintended pregnancy.
* 1995 - 1997 Data is Provisional (Not all census tracts coded + not all out-of-state births are included.)

For More Information Contact

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Progress

Objective 6

Suicide/Injurious Suicide Attempts

Reduce suicides and injurious suicide attempts by:

- Reducing suicide by 10% to no more than 9.2 per 100,000 people;
- Reducing the incidence of suicide attempts which lead to hospitalization by 15%.

Suicide is the second leading cause of injury death in Rhode Island. Unlike other states, all age groups are at-risk.

Why It's Important

Suicides are the second leading cause of injury deaths in Rhode Island, accounting for one-fifth of all such deaths. Suicide and suicide attempts cost Rhode Island over $61 million in 1996 in hospital costs and lost wages (Children's Safety Network). Because of the resulting blame and stigma, suicide often becomes a double tragedy for surviving family and friends. Its effect on those left behind can be overwhelming, and in fact, a close relationship with a suicide victim may place survivors at risk for suicide themselves.

According to 1997 YRBS data, 24% of high school students in RI seriously considered attempting suicide in the past 12 months compared to 20.5% nationwide, and 10% attempted suicide in the past 12 months compared to 7.7% nationwide. During the period 1993-1997, suicide was the fourth leading cause of death for teens ages 15-19 (RI Kids Count Factbook, 1999).

Individuals who complete a suicide attempt are most likely to be white males 18 and over. Those who survive suicide attempts are most likely to be adolescent females.

What We Have Achieved

The Department of Health serves as a catalyst to increase public awareness, develop collaborative relationships among concerned parties, facilitate statewide planning, encourage research, evaluate prevention strategies, and assure access to necessary treatment.

As part of the Northeast Injury Prevention Network (NEIPN), the Department of

Health successfully secured funding from the Centers for Disease Control and Prevention (CDC) for a bi-regional suicide prevention planning conference. This conference was held in June 2000 and aimed to support and assist in the creation of state action plans to reduce and prevent suicides.

Also in conjunction with the NEIPN, the Violence Prevention Program summarized state suicide data for inclusion in a bi-regional suicide data book developed by the Children's Safety Network.

Finally, the Department of Health collaborated with the Department of Education and community members to revise the health education outcomes and standards around child abuse, mental health, safety, and injury prevention, including suicide.

2010 Notes

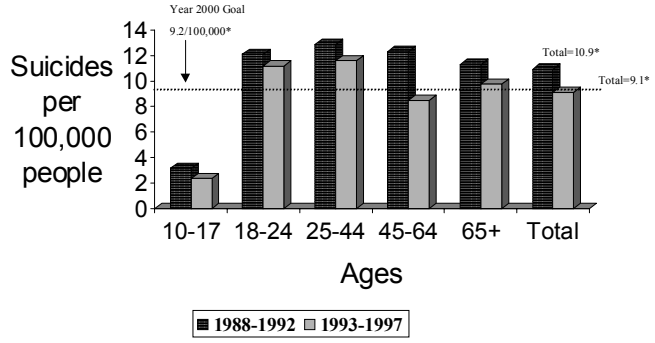
Given the distribution of completed suicides in Rhode Island, it is important to develop a comprehensive statewide plan for suicide prevention that targets all ages. The two methods most commonly used in completed suicides are firearms and suffocation (caused by hanging). It is, therefore, imperative to reduce availability of means (e.g., firearms) through legislative advocacy to reduce the severity of self-inflicted injuries.

Key Collaborators

>The Samaritans >The Mental Health Association >Council of Community Mental Health Centers >RI Department of Education >RI Department of Mental Health, Retardation, and Hospitals >RI Department of Children Youth and Families >Northeast Injury Prevention Network >Education Development Center >The Children's Safety Network

By the Numbers

Average Suicide Rates Among Rhode Islanders by Age Group



*Age-adjusted rates

Suicide rates among all age groups 10-65 decreased during the period 1993-1997. However, unlike national trends which show the highest suicide rates among people over age 65, in Rhode Island rates are more evenly distributed across the age groups for people 18 and over.

While the number of suicides among non-Hispanic Whites is far greater than the number of suicides among non-Hispanic Blacks during the period 1992-1996, the age-adjusted suicide rate per 100,000 people is the same.

Suicides by Race and Ethnicity, Ages 10-65+, 1992-1996

	Non-Hispanic White	Hispanic	Non-Hispanic Black
Number of Suicides	76	3	3
Suicide Rate per 100,000*	9	5	9

*Age-Adjusted

Sources:

Data for the suicide objective were obtained from the Office of Health Statistics.

Sources include the Hospital Discharge Data system and vital statistics records.

YRBS data obtained from both the 1997 RI YRBS published results and the CDC.

RI Kids Count Factbook, 1999.

Children's Safety Network.

For More Information Contact

Beatriz Perez or Deb Stone, Manager and Program Planner, HEALTH, Violence Prevention Program; telephone: (401) 222-4420; e-mail: BeatrizP@doh.state.ri.us or DebS@doh.state.ri.us

Progress

Objective 7

Mental Disorders

Reduce the prevalence of mental disorders by:

- Reducing the prevalence of mental disorders among children and adolescents to less than 10%;
- Reducing the prevalence of mental disorders (exclusive of substance abuse) among adults living in the community to less than 11 %.

Reducing the prevalence of mental disorders is crucial to improving the quality of individual lives and improving the social and emotional health of the population at large.

Why It's Important

Approximately 98,000 adult Rhode Islanders are affected by mental disorders. Some 9,000 of them have severe and persistent mental illness involving functional limitations which affect their ability to deal with activities of daily living. For them, improvements in mental health are measured by increase in their ability to lead satisfying lives within the limitation of their illness. That ability is improved through holding jobs in competitive employment, managing their own lives, and living independently. The remaining 89,000 adults have mental health problems such as depression and anxiety, stress reactions, and physical complaints with no identifiable organic cause.

Over 10 percent of Rhode Island's 225,049 youths from birth to age 18 are affected with a Severe Emotional Disturbance (SED), a condition affecting youth and families in education, criminal justice, health, and other activities of daily living.

What We Have Achieved

Increasing access to treatment is a key factor in reducing the prevalence of mental disorders. Adults with serious and persistent mental illness receive community mental health center services through the Department of Mental Health, Retardation & Hospitals Community Support Program (CSP). Jobs, housing, and intensive treatment are of high priority for them. In the 1996-2000 period, the mental health system has:

- Doubled the number of adults with a co-occurring substance abuse disorder receiving intensive services to 900.
- Tripled the number of adults getting jobs in competitive employment to 845.

- Created housing for 100 formerly homeless adults with mental illness.
- Created 248 housing units for other adults with mental illness.

For children and adolescents, the Department of Children, Youth & Families has guided provision of services for:

- 2,500 youths and their families through Local Coordinating Council Teams.
- 1800 children and youths at risk for hospitalization or out-of-home placement.
- Psychiatric hospitalization to 400 children and youths.
- Intensive supervision and case management to youths returning to the community from the Training School, or who are on probation.

2010 Notes

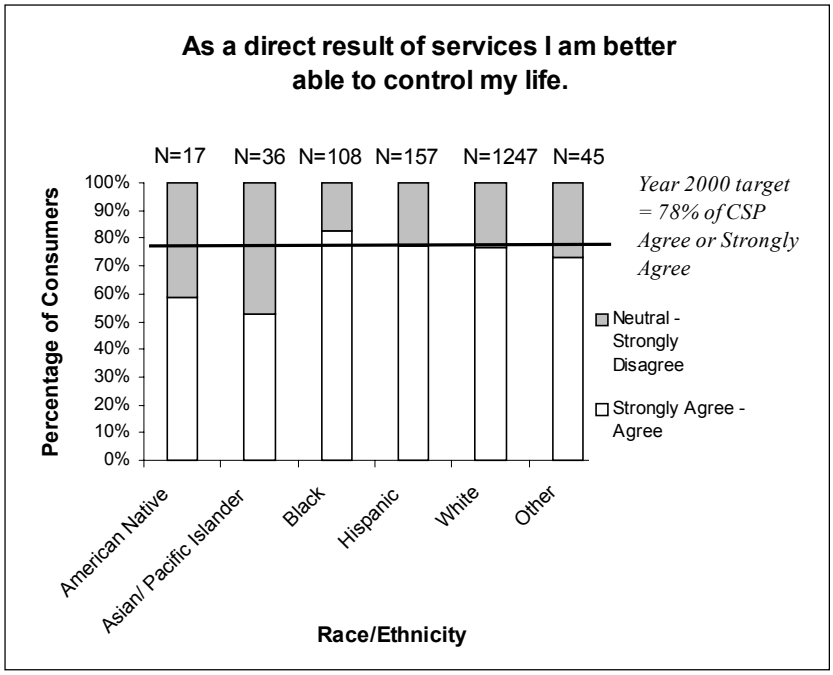
By FY 2000, it will be possible to match improvements in adult mental health with objectives established for various aspects of personal growth and independence.

Recovery is the overall goal for adults. Recovery is a process of changing one's attitudes, values, feelings, and goals. It is a way of living a satisfying life even with the limitations caused by illness. It can be measured not only by symptom mitigation, housing improvements, gains in education and employment, but by the degree to which the person develops self-esteem and self-confidence and achieves an integration into the community. Those gains are now being measured through an outcome evaluation process. Some sample measures are shown on the next page.

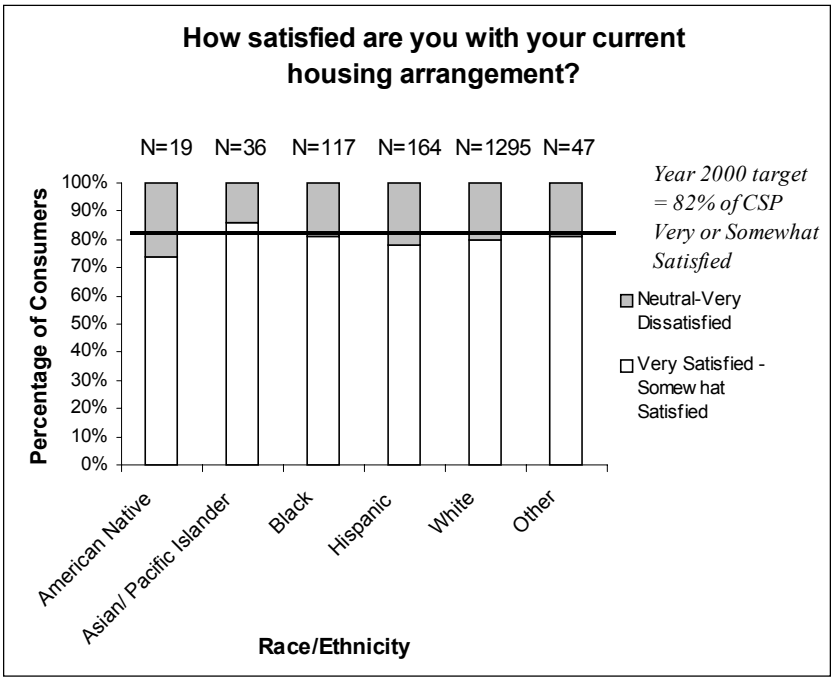
Key Collaborators

>RI Department of Mental Health, Retardation, and Hospitals, Division of Integrated Mental Health Services >RI Department of Children, Youth & Families >RI Department of Elderly Affairs >Community mental health centers >Eleanor Slater Hospital >Community hospitals >Mental Health Consumer Advocates >Alliance for the Mentally Ill >Governor's Council on Mental Health >Mental Health Advocate's Office

By the Numbers



The proportion of people who respond that they are better able to control their lives is a key measure of personal satisfaction and independence.



The proportion of people who respond that they are satisfied with their housing is a key measure of satisfaction with life.

For More Information Contact

Paul Carvisiglia, Director, Planning and Evaluation, Division of Integrated Mental Health Services, Department of Mental Health, Retardation, and Hospitals; telephone: (401) 462-6029; e-mail: pcarvisiglia@mhrh.state.ri.us;
George McCahey, Community Services Coordinator, Children's Behavioral Health, Department of Children, Youth and Families; telephone: (401)222-5246; e-mail: gmccahey@dcyf.state.ri.us

Progress

Objective 8

Homicides and Assault Injuries

Reduce homicides and assault injuries by:

- Reducing homicides by 15%, to no more than 2.4 per 100,000 people;
- Reducing assault injuries leading to hospitalization by 10%, to no more than 36.9/100,000 people.

Young men and minorities are at increased risk of homicide. Women and teens are at-risk of assault associated with dating/ domestic violence.

Why It's Important

The U.S. continues to rank first among industrialized nations in violent death rates, and violent assaults are a significant cause of injury and disability. The U.S. homicide rate for persons 15 to 24 is higher than the combined total homicide rate of the top 11 industrialized nations (OJJDP Fact Sheet 2/99).

Young men in Rhode Island are at greatest risk for victimization and perpetration of violence. Homicide was the second leading cause of death for all teens 15 to 19 between 1993 and 1997 accounting for many years of productive life lost (RI Kids Count Factbook 1999).

The Hispanic population is at an increased risk for homicide. According to the Rhode Island Office of Minority Health's "Minority Health Facts," between 1991-1993, homicide was the third leading cause of death for this group.

Women are vulnerable to both physical and sexual assault perpetrated by spouses, ex-spouses, and other intimate partners or acquaintances. Numbers of deaths in RI attributable to domestic violence-related incidents, including, women, children, and bystanders have risen during the period 1988-1997. From 1993-1997 there was an average of 4 deaths per year, up from an average of 2.8 deaths per year during 1988-1992 (RI Coalition Against Domestic Violence).

Teen dating violence (TDV) may be an important precursor of adult domestic violence. Preliminary data from the RIEAP, Student Assistance Program's Teen Dating Violence Prevention Project, funded by the Department of Health in 1997 suggest that middle school students may be significantly impacted by TDV. Fifty four percent (54%) of the middle school students self-reported having ever dated or

"gone out with" someone and/or having gone steady with a girl/boyfriend in the past year. Pairing up in either of these types of relationships increases the risk of TDV. Of the paired students, 15.4% had already been victims and/or perpetrators of minor TDV (UNH presentation, 1999)

What We Have Achieved

In 1995, Rhode Island's Violence Against Women Prevention Program (VAWPP) received funding from the Centers for Disease Control and Prevention for the development of a data system for improved documentation of the number of victims, perpetrators, and incidents of intimate partner violence (IPV). This funding also allowed the Department to increase the "core-capacity" of schools to implement the RI Teen Dating Violence Prevention Program (TDVPP) in 10 Rhode Island middle schools. The TDVPP has been successfully implemented and evaluated. The VAWPP recently received continued funding for surveillance activities through September 2000.

2010 Notes

The arrival of a Public Health Prevention Specialist assignee from the U.S. Centers for Disease Control and Prevention will enable HEALTH to develop a plan for the Department's continued role in violence prevention. This plan will include strategies to continue statewide planning, coordination, and assessment of violence prevention programs, services, and strategies to increase surveillance capabilities to capture information on assault injuries and homicides for men and women of all ages.

The Department of Health is dedicated to working with community groups involved in violence prevention work. Using Prevention Block Grant funding, the Department has supported school and community-based sexual assault prevention programs conducted by the Sexual Assault and Trauma Resource Center.

Established in 1997, The Rhode Island Anti-Violence Coalition received, and continues to receive key leadership from the Department of Health. On behalf of the Coalition, the Violence Prevention Program developed a statewide directory (currently in draft form) of youth violence prevention and intervention programs.

The Department also collaborated with the Department of Education and community members to revise the Health Education Outcomes and Standards around child abuse, mental health, and safety and injury prevention.

Finally, in order to provide the latest research on violence prevention, the Department of Health hosted a national video satellite conference series sponsored by the Partnerships for Preventing Violence. People from around the state came to the Department of Health to both view and participate in the activities associated with this national broadcast.

Key Collaborators

>Brown University > RI Employee Assistance Program >University of Rhode Island Family Violence Research Program >Office of the Attorney General >RI Medical Society >Office of the Medical Examiner >Joint Legislative Commission

to Study Women's Health Issues >Hospitals and health care providers >Batterers intervention programs >RI Department of Education >RI Department of Mental Health, Retardation, and Hospitals >RI Department of Children Youth and Families >Sexual Assault & Trauma Resource Center >RI Anti-Violence Coalition

By the Numbers

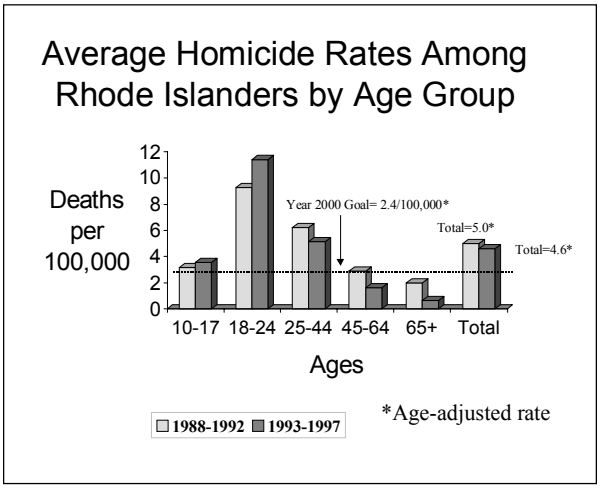
Domestic Violence Incidents: Estimates from the Surveillance Systems of Violence Against Women**

Years	1995	1996	1997	1998
Estimated incidents*	5171	5298	5634	5813

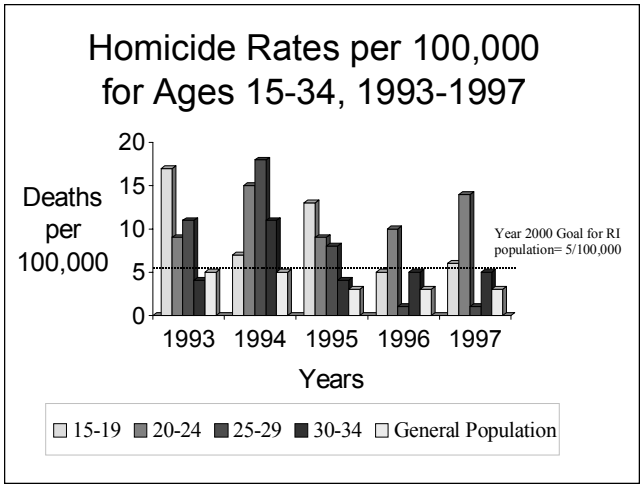
*Estimated incidents represent only those incidents captured by the surveillance system, based on criminal justice data, and which have "probable cause." Probable cause according to the RI Supreme Court is defined as "knowledge of those facts and circumstances along with reasonable trustworthy information that would cause a prudent officer to believe that the suspect had committed a crime."

** Data includes information on both male and female victims, of which, approximately 80% are women.

Preliminary analyses of data from the Health Department's Violence Against Women Surveillance System show that the number of reported incidents of domestic violence and sexual assault has increased steadily since 1995.



While homicide rates for the total Rhode Island population have decreased during 1993-1997 compared to 1988-1992, homicide rates for youth and young adults have increased during this same time period. For the period 1993-1997, the homicide rates for people ages 18-24 are more than double the rates for the total RI population (Office of Health Statistics).



Sources

Office of Juvenile Justice and Delinquency Prevention (OJJDP) Fact Sheet 2/99
National Center for Injury Prevention and Control
RI Kids Count Factbook 1999
Office of Minority Health's "Minority Health Facts"
UNH presentation, 1999

For More Information Contact

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Progress

Objective 9

School Health Education

Provide quality school health education by increasing the number of schools that:

- Require health education as a separate course;
- Have health education as a graduation requirement;
- Require a student to repeat a failed health education course;
- Support in-service training or staff development;
- Have health educators certified or endorsed to teach health education;
- Have health educators with a major emphasis on health education in their professional preparation.

Health education is one component of a total school orientation for health which includes addressing a healthy environment, physical education and activity, nutrition, counseling and psychological services, health services, health promotion for faculty and staff, and family and community involvement.

Why It's Important

A comprehensive and coordinated school health program (CSHP), which includes quality health education as one of its eight components, addresses children's immediate and long-term health issues at a time when they can build life-long healthy behaviors and reduce risk taking behaviors. Well-educated children and youth will reduce their risk of unintentional injuries and violence as well as chronic diseases through their choices of healthier behaviors.

The demands on educators to demonstrate improved academic achievement for **all** children often pull educators' attention away from health education. However, students' good health is an important underlying component of their ability to learn and be successful both now and in their adult lives.

Health education is one component of a total school orientation for health which includes addressing a healthy environment, physical education and activity, nutrition, counseling and psychological services, health services, health promotion for faculty and staff, and family and community involvement. Schools must implement all those components to support students in healthy behaviors.

What We Have Achieved

The Departments of Education and Health have led the state in the *Healthy Schools! Healthy Kids!* initiative to pull together state and local partners to support CSHP in schools throughout Rhode Island. The School Health Advisory Committee (SHAC) has been convened as a body to carry forward the recommendations contained in "Rhode Island's Plan for Comprehensive School Health Programs." Through group and individual efforts a number of resources and policy changes have improved the opportunity for schools to produce healthy students.

- The "asset protection" provision of Article 31 governing educational reform ensures that all schools will plan systematically to maintain and improve their physical environment.
- The Health Education Resource Center provides materials for health educators to utilize in teaching health concepts.
- All schools have tobacco control policies in place.
- The *Healthy Schools! Healthy Kids!* website provides resources for students, teachers and families who are interested in school health topics.
- The School Lunch Cook Off has highlighted the importance of nutritious meals which taste good.
- Rhode Island health education standards set the guidelines for what children should learn in their classes.
- The Rules and Regulations for School Health Programs have been systematically reviewed and updated to support CSHP, including sections on School Health Education, Health Services, and Healthy School Environment.

2010 Notes

The philosophy underlying how to achieve effective schools has changed dramatically in this decade, and our ability to survey schools to assess changes has been reduced. Measures of school health will need to be carefully selected for their viability in the current school climate.

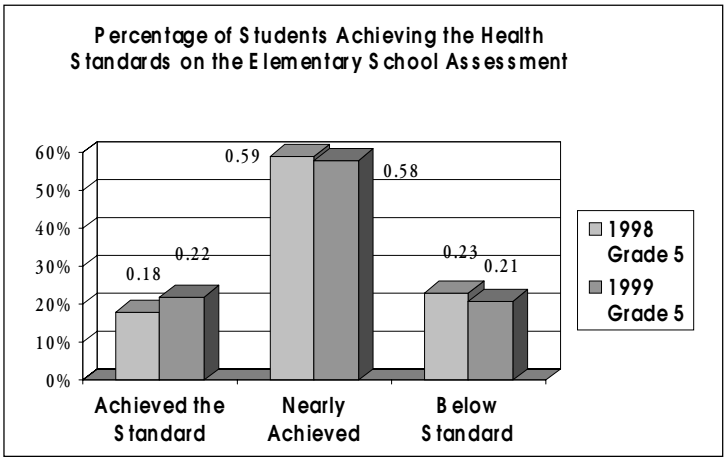
Key Collaborators

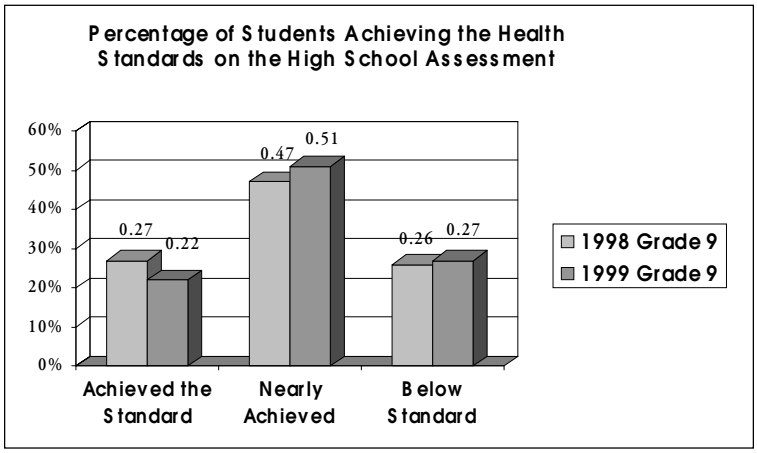
>The School Health Advisory Committee (SHAC), which includes over 100 members from local schools and districts (including teachers, administrators, school nurse teachers, counselors, facilities managers, parents, community-based organizations, State agencies and statewide advocacy and practice groups

By the Numbers

Since 1998, all Rhode Island students in grades 5 and 9 take the Health Education Assessment, a test consisting of multiple choice and open ended questions to assess students' ability to meet the health education standards as set forth in the RI Health Education Framework, "Health Literacy for All Students."

The graphs below show the results of the assessments for 1998 and 1999. As teachers move toward standards-based health education, we will expect to see a rise in the proportion of students who meet the standard. Information about the Health Education Assessment can be retrieved from www.infoworks.ride.uri.edu/.





For More Information Contact

Ann Kelsey Thacher, Chief, HEALTH, *Healthy Schools! Healthy Kids!* initiative; telephone: (401) 222-3442; e-mail: AnnT@doh.state.ri.us; Linda Nightingale Greenwood, Manager , Department of Education, Comprehensive School Health Programs; telephone: (401) 222-4600, x2364; e-mail: ride0062@ride.RI.net

Progress

Objective 10

Unintentional Injuries

Reduce unintentional injuries by:

- Reducing fatal unintentional injuries by 15% to no more than 22.5 per 100,000 people;
- Reducing hospitalizations for unintentional injuries by 15% to no more than 612 per 100,000.

Why It's Important

Unintentional injuries are the leading cause of death and disability for children and adults 1- 34 years of age.

Unintentional injury is the leading cause of death among children under 15 years of age in the United States. Nearly 6,300 children under 15 years of age died from unintentional injuries in 1996 and another 120,000 are permanently disabled. Each year, one out of every four children sustains injuries that are serious enough to require medical attention each year. These injuries have enormous financial, emotional and social effects on not only the child and the family, but the community and society as a whole.

Motor vehicle collisions are a major cause of unintentional injuries to Rhode Islanders. These include injuries to vehicle occupants, motorcyclists, bicyclists, and pedestrians. Many injuries and deaths also result from falls, poisonings, fires, drownings, and chokings.

Injuries are not random; they occur in predictable patterns based on the age and sex of the individual, the time of day, and the season of the year. For each type of injury, there are identifiable high-risk groups. Motor vehicle occupants not wearing seat belts or young children not restrained in child safety seats are at high risk. Bicyclists not using helmets are at high risk for traumatic brain injury. Boys 5-9 years of age and elderly women are at greatest risk for pedestrian injuries. Low-income urban households are at high risk for fatal fires.

What We Have Achieved

- Provided 16,000 bicycle helmets to youngsters in 10 communities since 1995 including 5000 helmets to children in low-income, minority communities.
- Assisted organizations to distribute another 2000 helmets to low-income children.
- Provided 1500 T-shirts to police departments for distribution to youngsters wearing helmets.

2010 Notes

On a national level, the unintentional injury death rate among children ages 14 and under declined 30% from 1987 to 1996. The motor vehicle death rate for this same population during this same period declined 7%, the bicycle injury death rate declined 51%, and the pedestrian injury death rate declined 38%. However, unintentional injury is still the leading cause of death among children ages 14 and under in the United States.

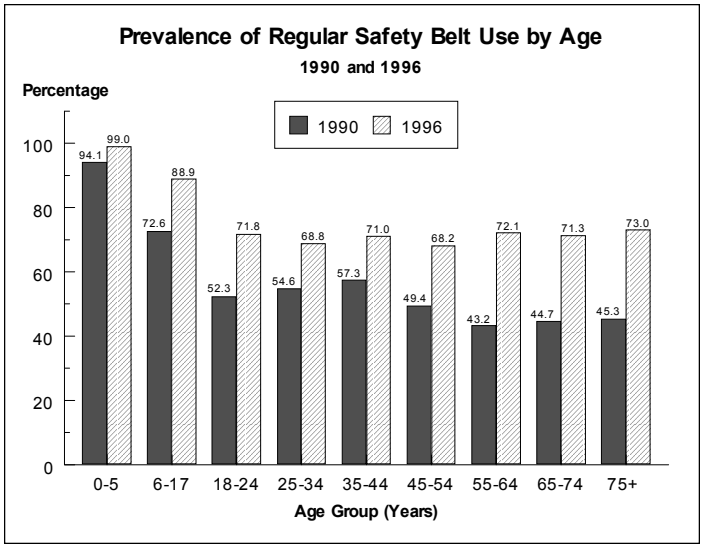
- Distributed more than 100,000 flyers to educate students and parents about bicycle helmet legislation in effect since 1996.
- Conducted 9 child safety seat check-up events , taught over 300 parents how to correctly install seats, and replaced unsafe seats for low-income families.
- Provided training and administered certification training for child passenger safety technicians.
- Distributed over 150,000 pieces of safety materials, literature, posters and videos to educate students and the general public about safety.

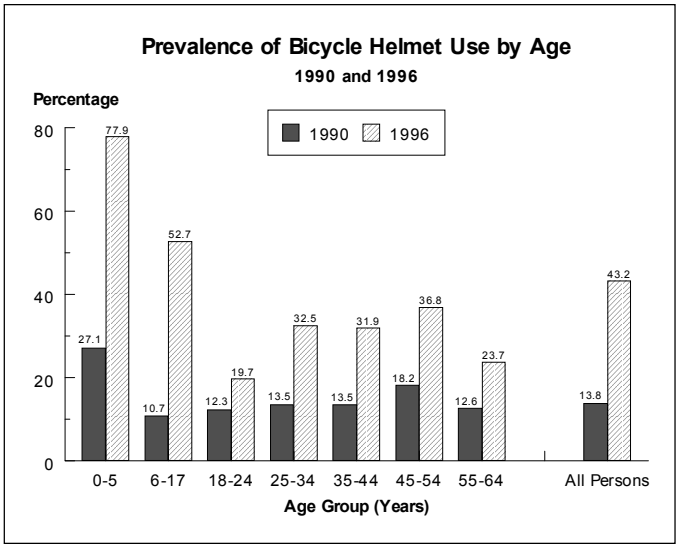
Key Collaborators

>The Governor's Office on Highway Safety > RI Department of Transportation >RI Department of Education >RI Department of Human Services >Rhode Island SAFEKIDS Coalition >Municipal Police Departments >Local school departments

By the Numbers

Prevalence of both regular seatbelt use and of bicycle helmet use have increased over the period measured. Use rates are highest among children. The next measurement period will be in 2001 when the next Health Interview Survey is conducted.





Data Source: 1990 and 1996 RI Health Interview Surveys.

For More Information Contact

Nancy Libby Fisher, Program Manager, HEALTH,Unintentional Injury Prevention Program; telephone: (401) 222-4420; e-mail: NancyL@doh.state.ri.us

Progress

Objective 11

Work-Related Diseases and Injuries

Identify, manage and prevent work-related diseases and injuries within Rhode Island by:

- Reducing the 5-year average work-related death, injury and illness rates by 25%.

Why It's Important

Workers in the public and private sectors should be able to perform their jobs in an environment free of recognized safety and health hazards.

Although the incidence rates for workplace injuries and illnesses have decreased over the past ten years, the rates continue to be unacceptable. Work-related fatalities in New England hit a seven-year high last year due to a regional rise in highway crashes, exposure to harmful substances, electrocutions, and drowning. The booming economy has contributed to the trend because more people are employed, many of them in high-risk construction jobs. Other challenges in worksite health and safety include increases in work-related violence, a high injury rate among adolescents and workers who are new to a job, and ergonomic factors involved in repetitive motion and lifting activities.

What We Have Achieved

Over the past decade, partnerships have been recognized as the key to reducing injuries and illnesses. The Department of Health has initiated numerous partnerships with federal and state agencies, as well as with individual businesses, labor groups and trade organizations. Achievements include:

- Collaboration with over 1,000 high hazard businesses for the identification and correction of safety and health hazards.
- Working with the Governor's Task Force on Safety and Health to set up safety and health committees in all state agencies, provide training to committee members, and develop guidelines for safe working procedures.
- Revising the rules and regulations for the reporting of occupational diseases in order to expand reporting requirements, increase the quality of surveillance data, and target intervention activities.
- Development of an adult blood lead epidemiological surveillance program, in partnership with the Centers for Disease Control, in order to collect

2010 Notes

- Increase the availability of technical assistance to the construction industry for both on-site consultation and worker training.
- Develop better assess - ment and surveillance mechanisms to character- ize and target risk factors.
- Increase workers' aware- ness of their rights to work safely, and employers' awareness of the eco- nomic incentives in reduc- ing workplace hazards.
- Continue targeting educa- tion efforts to specific in- dustries, e.g. back injury prevention to employees involved in lifting, lead and silica training to reduce ex- posures to employees.
- Develop initiatives to focus on injury prevention among adolescents and new work- ers.

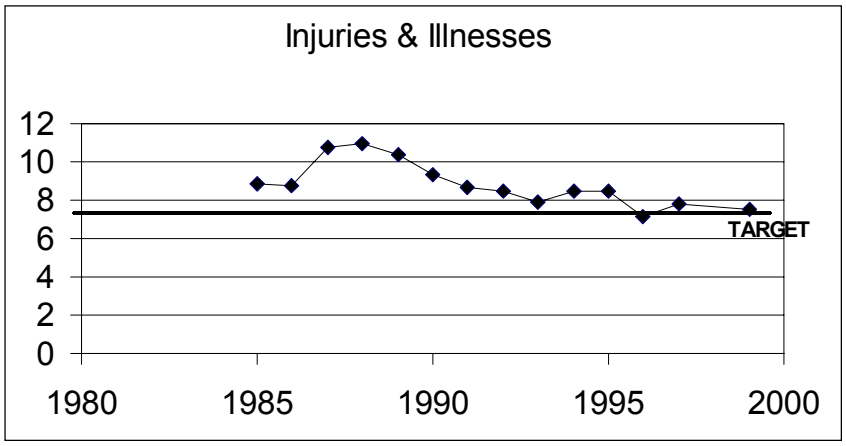
accurate data on lead exposure in industry.

- Participation in cooperative compliance initiatives with the Occupational Safety and Health Administration (OSHA) to encourage private sector employers to develop safety and health programs for the ongoing recognition and correction of hazards. This initiative focused on companies with the highest injury and illness rates, including the nursing home industry and the recycling industry.
- Ongoing partnerships with the Department of Environmental Management and OSHA to provide training to the construction industry regarding lead hazards and to provide technical assistance to the autobody industry in the areas of chemical emissions control and workplace safety.
- Licensing of asbestos abatement contractors, lead abatement contractors, and radon mitigation contractors to assure employees are trained to perform their work safely.
- Ongoing training initiatives with numerous partners, including the State Police, the Rhode Island Committee on Occupational Safety and Health (RICOSH), the insurance industry, and trade groups.

Key Collaborators

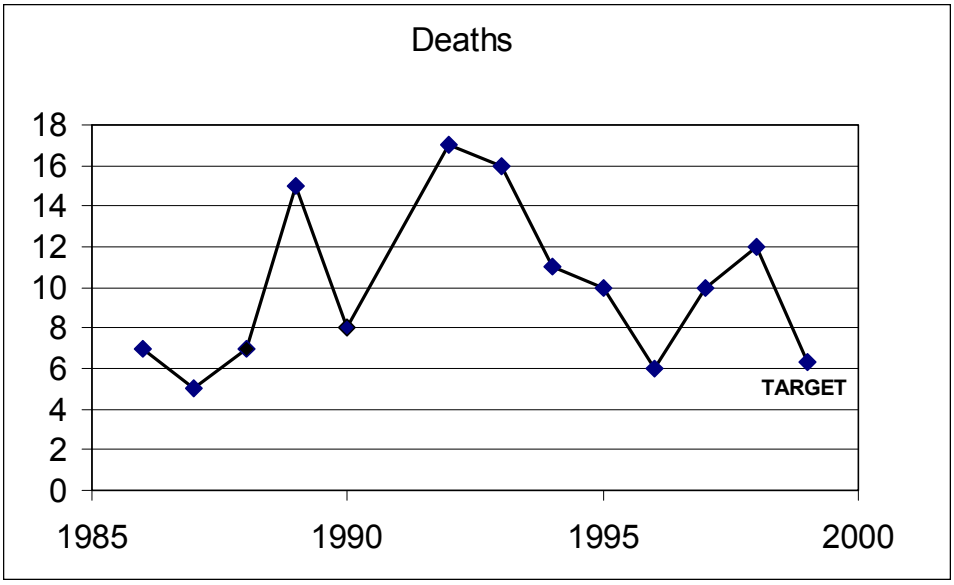
>U.S. Department of Labor >OSHA >RI Committee on Occupational Safety and Health >RI Department of Environmental Management >RI Department of Labor and Training >American Lung Association of Rhode Island >RI Safety Association >RI Association of Builders >Insurance companies >Business/trade associations

By the Numbers



Occupational injury and illness incidence rates per 100 full-time workers in Rhode Island are decreasing over time, from a high of 11.0 in 1988 to a low of 7.1 in 1996.

Data source: Bureau of Labor Statistics



Number of work-related deaths reported to OSHA for Rhode Island ranges from a high of 17 in 1992 to a low of 5 in 1987. The goal of 6, or fewer, has not been met.

For More Information Contact

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Progress

Objective 12

Children's Blood Lead Levels

To reduce children's blood lead levels by:

- Reducing the prevalence of blood lead levels exceeding 10 micrograms of lead per deciliter (10 µg/dL) of blood by 50%, and exceeding 20 µg/dL by 75%, among children through the age of 5 years.

Why It's Important

Rhode Island has the fifth oldest housing stock in the country and it is estimated that 90,000 units present moderate to high-risks to children living within them..

Lead is one of the most prevalent environmental toxins in the world. Lead poisoning is the most serious environmental health problem affecting Rhode Island's children. In 1999 the incidence of elevated blood lead levels in children was 9%, compared to 4% at the national level.
Despite the overall decline in blood lead levels, the continued high level of exposure for specific socio-demographics groups and the recent studies that indicate a significant relationship between low lead levels and toxicity, maintain lead poisoning as a public health concern.

Lead poisoning can impair a child's developing nervous system, resulting in long term adverse effects on neurocognitive function, deficits in learning and/or memory processes, and/or behavior problems. In Rhode Island blood lead levels of 20µg/dL or higher are considered significant lead poisoning for children. In 1999, 6 Rhode Island children were hospitalized.
Rhode Island has the fifth oldest housing stock in the country and it is estimated that 90,000 units present moderate to high-risks. In Rhode Island the major source of lead exposure for children continues to be lead-based paint.

What We Have Achieved

- Substantially increased the screening rate (as of 18 months of age) from 59% for children born in 1994 to 67% for children born in 1996. Most recent assessments made using KIDSNET data suggest that the rate is significantly higher, ranging between 75 to 80%.
- Significantly decreased the number of hospitalized children for acute lead poisoning, from 19 in 1993 to only 6 in 1999.
- Lowered the blood lead level at which lead-poisoned children receive a home inspection, (from 25 mg/dl to 20 mg/dl in 1997), substantially

increasing the proportion of children receiving this service.

- Significant expansion of our preventive services, by offering all children under six years of age with a venous lead level of 15 to 19 mg/dl, a lead education home visit through the Family Outreach Program (FOP).
- Implementation of the "enhanced case management" model under the Medicaid Waiver known in RI as RIte Care.
- Significant expansion of our assessment activities to better define the remaining pockets of inadequate screening practices thanks to the implementation of KIDS NET and to the partnership with the Department of Pediatrics at Brown University.
- Partnered with the Department of Children, Youth and Families to inspect more than 250 state-licensed daycare centers serving children under age six.
- Collaborated with HUD and local housing authorities to increase the supply of lead-safe housing available to low-income renters.
- Supported local enforcement through testimony in hundreds of housing court cases involving units with serious lead hazards.
- Restructuring of our primary prevention strategies through several partnerships, including the partnership with the City of Providence.

2010 Notes

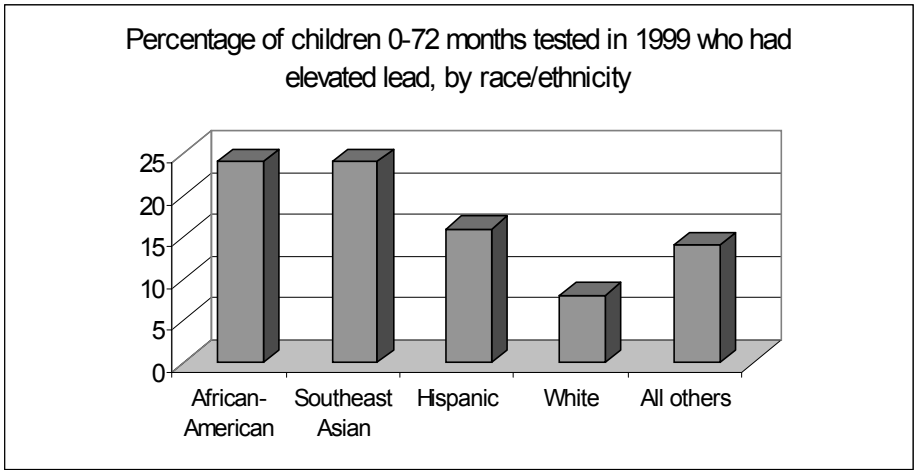
The Rhode Island Childhood Lead Poisoning Prevention Program will continue to ensure screening for at-risk children, and education of parents, child care providers, the medical community and lead professionals. We will:

- Increase lead screening rates using KIDS NET data tracking system and innovative partnerships.
- Expand treatment and environmental management programs for children with moderately elevated lead levels
- Increase the availability of lead-safe housing in Rhode Island
- Further lower the blood lead level at which lead-poisoned children receive a home inspection.
- Expand the "enhanced case management" services through the state.
- With the Rhode Island Department of Education, implement a program of lead hazard assessment in nursery and elementary schools.
- Better educate both the public and property owners on disclosure requirements of lead hazards prior to rental or real estate transfer, ways to prevent lead poisoning, and services available for families in Rhode Island.

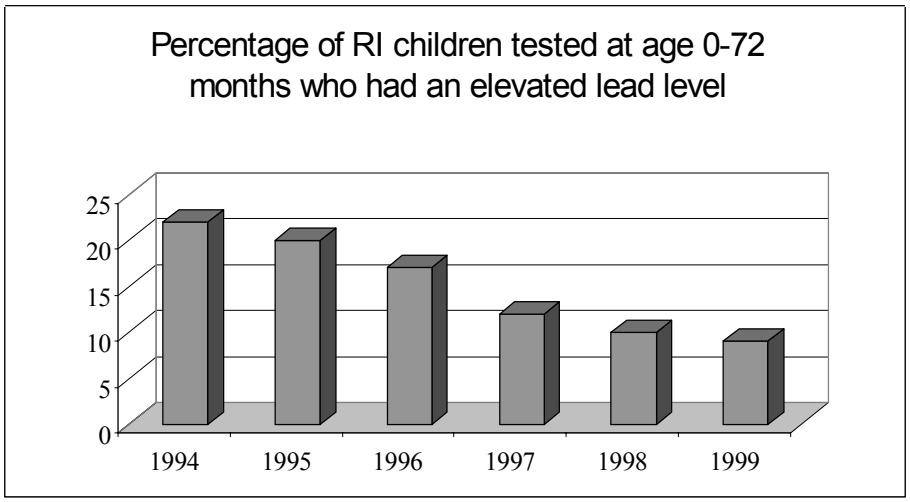
Key Collaborators

>RI Department of Children, Youth and Families >RI Department of Human Services >Attorney General's Office >RI Department of Environmental Management >City of Providence >City of East Providence >Rhode Island Housing >Community health centers >Hospital-based clinics >Private physicians >Commercial laboratories >Local housing enforcement authorities and Court Systems >Health Insurance companies >Licensed contractors and inspectors >Community-based agencies >School departments >Early childhood education agencies >Community organizations

By the Numbers



The prevalence of elevated blood lead in children under six is higher in racial and ethnic minority group members.



The overall prevalence of elevated blood lead in young children has been decreasing steadily but is still much higher than national levels.

Note: "Elevated lead" means lead level equal to or greater than 10 micrograms per deciliter (μg/dL) of blood.

For More Information Contact

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Progress

Objective 13

Environmental Tobacco Smoke

Reduce exposure to environmental tobacco smoke by:

- Reducing by 50% the number of children exposed to environmental tobacco smoke in enclosed spaces;
- Increasing to 50% the number of workplaces that are smoke-free.

Why It's Important

ETS exposure increases the risks for lung cancer, respiratory disease in children and asthma.

Environmental Tobacco Smoke (ETS or second hand smoke) is one of Rhode Island's leading environmental health risks. ETS is a known human carcinogen. It is more than an annoyance; it's a health hazard.

- Exposure to ETS increases the risk for lung cancer and other tobacco-related illnesses.
- Children exposed to ETS in the home have a higher risk for respiratory diseases such as bronchitis.
- ETS in the workplace provokes asthmatic attacks in adults with asthma.

What We Have Achieved

The Healthy People 2000 Goal of increasing the percentage of smoke free workplaces in Rhode Island to 50% was achieved 5 years ahead of schedule (Chart 1). The RI Department of Health (HEALTH), other public agencies, non-governmental organizations and community-based programs worked together to promote smoke-free workplaces, as well as other smoke-free public environments. The Coalition for Smoking or Health, a group that represents the local chapters of the American Cancer Society, the American Heart Association and the American Lung Association spearheaded advocacy efforts for tobacco control legislation. The Workplace Smoking Pollution Control Act now applies to all employees, not just those at large businesses, and consideration must be given to the preferences of non-smoking employees. Other partners include members of the Worksite Wellness Council of Rhode Island. Member businesses are dedicated to improving the health of their employees through improvement of workplace smoking policies and assisting employees who desire to quit smoking.

In Rhode Island, exposures to environmental tobacco smoke (ETS) have substan-

tially declined since legislative and regulatory restrictions on smoking tobacco were first enacted in 1986. Key legislation includes the Workplace Smoking Pollution Control Act (1986), Smoking in Public Places Act (1985), Smoking in Schools Act (1994) and Smoking in Nursing Homes Act (1996). In addition to their legislative advocacy work, the Coalition for Smoking or Health has been active in efforts to restrict youth access to tobacco, to enforce existing bans on the sale of tobacco to minors, and to initiate and support municipal ordinances restricting smoking in public places.

2010 Notes

There is still progress to be made in protecting Rhode Islanders from ETS in workplaces and public places. Children and other members of the non-smoking public routinely suffer environmental tobacco smoke exposures in restaurants, mini-marts and other businesses that allow smoking. HEALTH receives about 3000 new applications for licensed food establishments each year, providing an opportunity to educate new proprietors on the importance of ETS as an environmental health hazard and to encourage these applicants to make their businesses smoke free.

- Continue current work place enforcement efforts while expanding voluntary programs to expand the number of smoke-free workplaces.
- Enhance smoking restrictions in restaurants and other public places frequented by children.

By the Numbers

Improvements in Rhode Island's workplace smoking policies from 1992 to 1995 are clearly demonstrated in Figure 1. Both local events and national activities, like the US Environmental Protection Agency classifying environmental tobacco smoke as a known human carcinogen, helped more than double the number of smoke-free workplaces in just three years. The number of workplaces with either poor smoking policies, or no policies at all, dramatically declined as well.

The Coalition for Smoking or Health has been active in efforts to restrict smoking in public places, especially places children frequent. To address the latest legislative restriction on smoking that banned smoking in laundromats and other public laundries, HEALTH received invaluable assistance from local Substance Abuse Prevention Task Forces. Task Force members are credited with gaining compliance with the smoking ban at the 30% of laundries that continued to allow smoking a year after the law was passed.

Key Collaborators

>The Coalition for Smoking or Health (a group which represents the local chapters of the American Cancer Society, the American Heart Association, and the American Lung Association) >Worksite Wellness Council of Rhode Island >Local Substance Abuse Prevention Task Forces

Table 1. Smoke-free areas in Rhode Island*

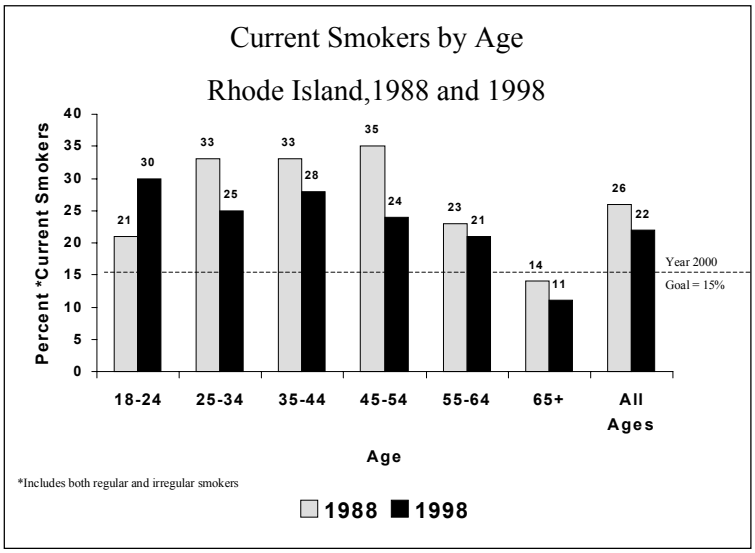
Workplaces:
More than two-thirds of RI workplaces are smoke-free.
All workplaces must have written policies.

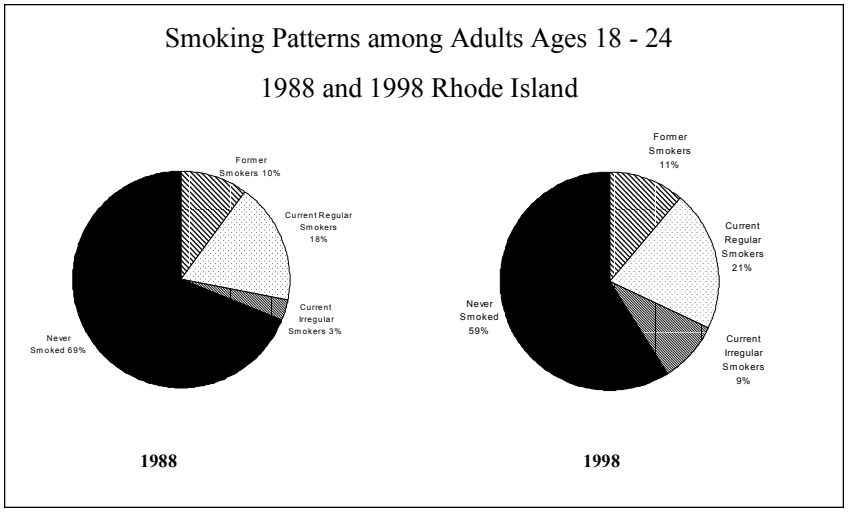
Public places:
Movie theaters, concert halls and auditoriums
Libraries, art galleries and museums
State house and courthouses
Medical offices and hospitals
Supermarkets and laundries
Elevators
Buses

Schools:
All primary, secondary and post-secondary schools
All colleges and universities

Nursing homes:
More than 50% of RI nursing homes are smoke-free.
All hallways and common areas are smoke-free.

* Data presented in Table 1 came from a survey of RI businesses, the results of which were published in the Health By Numbers column of RI Medicine. Data on nursing homes and public laundries were obtained by surveys conducted in the summer of 1999 by a student intern working under the direction of Robert Vanderslice.





For More Information Contact

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Progress

Objective 14

Radon

Reduce the risk to health from radon by:

- Reducing the number of occupied buildings that have radon levels >4 pCi/L, which are unacceptably high, by 50%.

Why It's Important

According to studies, one-tenth of lung cancer deaths may be due to radon in the home.

Radon is a naturally occurring radioactive gas that is odorless, colorless, and tasteless. It comes from the natural decay of uranium that is found in nearly all soils in the United States. Radon gas can seep into homes, schools or other buildings and build up to levels that can be unhealthy.

Approximately 23% of the homes in Rhode Island have radon levels that exceed the level considered acceptable by the Environmental Protection Agency (EPA). Of these homes, about 1-2% has radon levels five times the accepted standard.

Radon is a cause of cancer in humans, and is second only to cigarette smoking as a leading cause of lung cancer in the United States. There are approximately 100 deaths per year in Rhode Island due to radon-related lung cancer. Smokers who are exposed to radon may have a ten-fold higher risk than non-smokers.

The only way to determine the level of radon present is to test homes and other buildings. If a radon problem is identified, there are a variety of methods for cost-effective radon reduction (mitigation).

What We Have Achieved

- 90% of all schools in RI have completed initial radon testing.
- Rules and Regulations for Radon Control were developed and implemented in 1994.
- 85% of all state and municipal buildings have completed initial radon testing.
- Maintained a licensing and certification program to insure the consumer of getting qualified personnel.
- Hosted training courses and exams in RI to facilitate the licensing and certification process.

2010 Notes

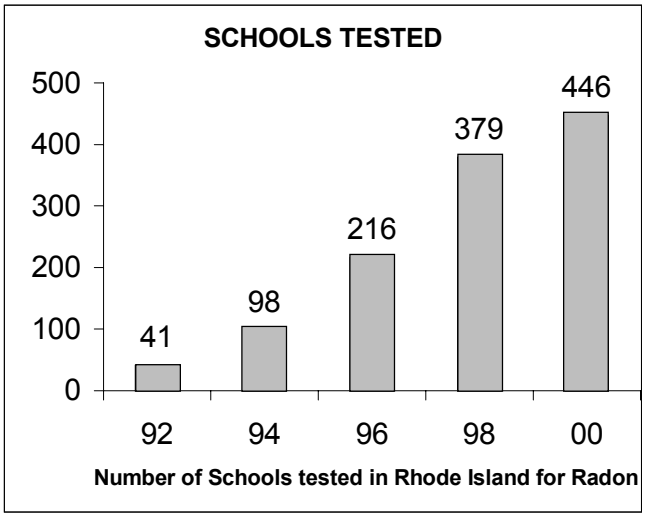
- To have 100% testing of Schools and Public Buildings.
- To have 100% of all child care facilities tested.
- To reduce any occupied area of a school, daycare, or public building to an acceptable level.
- Work to encourage homeowners and commercial building managers to test for radon.
- Work with the RI Building Code Commission to adopt new building codes to include radon resistant new construction methods.
- To work together with our partners utilizing public outreach and awareness to prevent the occurrence of lung cancers due to exposure to radon.

- The program has had a number of outreach activities, including:
  - -participation in health fairs and events;
  - -speaking to realtor associations and trade organizations;
  - -interviews on radio shows;
  - -newspaper advertisement campaigns;
  - -sponsoring workshops;
  - -providing educational materials.
- Have been able to increase the number of homes tested in RI in almost each of the last five years.

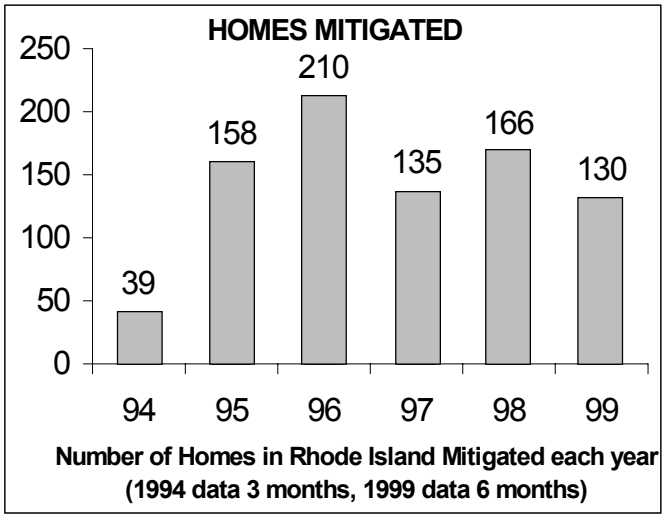
Key Collaborators

>U.S. Environmental Protection Agency > Rhode Island Building Code Commission >American Lung Association of Rhode Island >Rhode Island Association of Builders >Rhode Island Realtors Association >Brown University, Center for Environmental Studies >University of Rhode Island, Geology Department

By the Numbers



There are 493 public, private and/or parochial schools in Rhode Island. Since the beginning of the radon program in 1992, 446 (90 %) schools have been tested for radon.



Number of homes mitigated for radon in Rhode Island since Rules and Regulations for Radon went into effect in October 1994. These mitigations will help in the reduction of lung cancer cases due to exposure to elevated levels of radon.

For More Information Contact

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HEALTHY PEOPLE 2000 RHODE ISLAND 2010

Progress

Objective 15

Drinking Water Quality

Reduce the risk to health from drinking water by:

- Increasing to at least 85% the proportion of people receiving drinking water that meets federal standards.

The Department of Health works closely with Rhode Island public water systems to achieve compliance with all drinking water standards.

Why It's Important

Contaminated drinking water can have adverse health effects including gastrointestinal illness, cancer, and nerve damage.

We expect safe drinking water. While water suppliers strive to improve drinking water quality and comply with increasingly stringent regulations, they face greater challenges in meeting these goals. Contamination threats include development pressure, aging infrastructure, non-point source pollution such as pesticides, leaking underground storage tanks, and malfunctioning septic systems.

The Safe Drinking Water Act (SDWA) sets uniform minimum standards for drinking water quality to protect public health. Ninety-two contaminants are now regulated, including pathogenic organisms, toxic chemicals, and carcinogens. New rules are addressing emerging health threats such as *Cryptosporidium* and attempting to balance the competing risks and benefits of enhanced protection from pathogens while minimizing the formation of disinfection by-products.

Compliance with all of the drinking water quality standards all of the time indicates that a water system is doing a good job at providing a quality product and protecting public health.

What We Have Achieved

Regulatory Activities: implemented new, more stringent drinking water regulations for over 50 contaminants; certified 200 water treatment or distribution operators; tripled the number of water system inspections per year and reduced the number of total coliform violations by 30%.

Planning and Technical/Financial Assistance Activities: completed an infrastructure needs assessment for all community drinking water systems and, in partnership with the Clean Water Finance Agency, implemented a Drinking Water Revolving Loan Fund; developed a statewide Source Water Assessment Plan which will identify and report to the public known threats to drinking water sources; granted monitoring waivers for drinking water sources that are not vulnerable to contamination reducing anticipated monitoring costs by 67%; and received approval for a new water system capacity assurance plan which will assure that all new small water systems have the financial, managerial, and technical capacity to provide safe drinking water well into the future at the time that they receive initial approval.

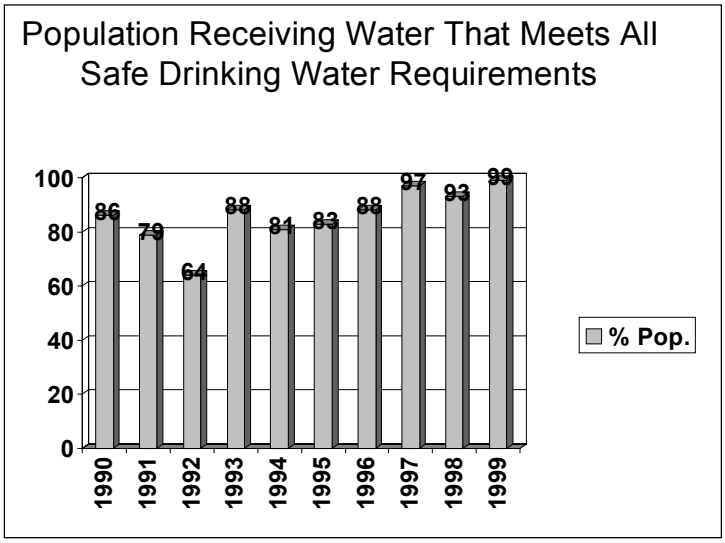
2010 Notes

During the coming decade, the mandates of the federal Safe Drinking Water Act will challenge public water suppliers to meet: drinking water quality standards that are even more stringent than the current standards; treatment requirements that are more complex and costly than current requirements; and higher standards of public accountability. Consumers will be challenged to advocate for improved drinking water source protection and enhanced treatment in the face of significantly greater costs and on-going development pressures.

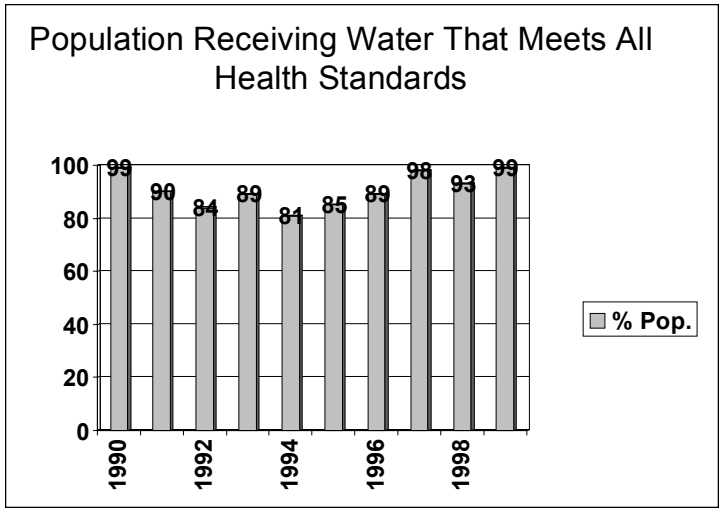
Key Collaborators

>Public water system owners/operators >Rhode Island Water Works Association >United States Environmental Protection Agency (EPA) >Municipal Governments >RI Department of Environmental Management >RI Water Resources Board >RI Public Utilities Commission >Clean Water Finance Agency

By the Numbers



"All Safe Drinking Water Requirements" include not only the health standards, but also all other requirements such as those related to treatment, monitoring, record keeping, and reporting of data. This bar graph indicates the percentage of the population served by public water systems that complied with all of the requirements during the years indicated.



This bar graph indicates the percentage of the population, served by public water supplies, that received drinking water that met all of the health standards for the years indicated.

For More Information Contact

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Progress

Objective 16

Foodborne Pathogens

Reduce infections caused by foodborne pathogens:

- And specifically reduce the incidence of infection by salmonella species to no more than 16 per 100,000 population.

Why It's Important

Foodborne illness can be life threatening, particularly for young children, the elderly, and those with weakened immune systems.

While everyone is at risk of illness from unsafe food, foodborne illness can be life threatening for young children, the fetus, the elderly, and people with weakened immune systems. Individuals with cancer, diabetes, liver or kidney disease, or AIDS are especially at risk. People regularly taking antacids and certain medications may be at higher risk of foodborne illness. Certain foodborne illnesses can cause long-term health problems such as kidney and neurological damage. From 1% to 3% of individuals with salmonellosis can suffer from a form of reactive arthritis lasting for six months or more.

The salmonella isolation rate in Rhode Island in 1989 was over twice the national Year 2000 health objective target, and 20% of these individuals were admitted to a hospital for treatment. Salmonellosis is only one of many foodborne illnesses. Total foodborne illness and subsequent person-to-person transfer of illness is estimated by the federal Food and Drug Administration (FDA) and the United States Department of Agriculture (USDA) to affect at least 1 person out of every 10 each year. Using this projection, it is estimated that at least 100,000 individuals become ill from foodborne pathogens in Rhode Island each year.

What We Have Achieved

- Approximately 7,700 food operation managers have been certified in food safety since 1992. There are over 5,000 individuals currently certified of which 2,500 are re-certified.
- In 1994, Rhode Island became the first state in the nation to adopt the new FDA model Food Code. New requirements include that there be no direct hand contact of ready-to-eat foods, and that pasteurized rather than raw eggs be used in foods requiring eggs.

- Training has been provided for Home Economics teachers to establish safe food-related behavior in the schools.
- Rhode Island is the first state to require food establishment operators to inform consumers that certain menu items contain raw or undercooked ingredients which can increase their risk of illness.
- Rhode Island has prohibited the sale of undercooked hamburgers to children 12 years of age and younger due to the risk of death or permanent kidney damage from *E. coli* O157:H7 bacteria.
- HEALTH has established a statewide Epi-Team that includes representatives from the Office of Food Protection, Communicable Disease, and Health Laboratories. This working group responds to incidences of foodborne illness outbreaks.
- Shellfish safety has been substantially improved through increased inspection and enforcement efforts.
- The incidence of salmonella decreased from 32 to 16.1 cases/100,000 between 1990 and 1998.

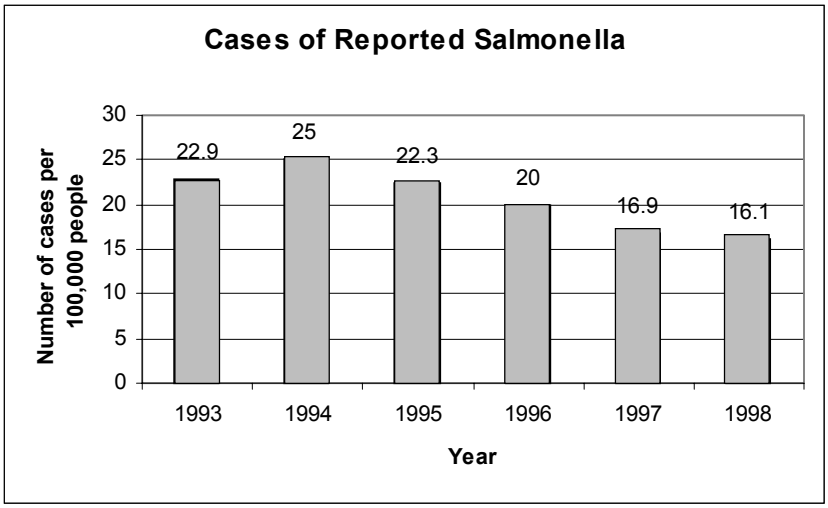
2010 Notes

- Obtain additional staff to inspect all food establishments an average of twice per year. At present, many food establishments have not been inspected in over two years.
- Ensure that 100% of food establishments have a manager certified in food safety.
- Conduct programs specifically directed at minority groups.
- Incorporate food safety education in school health programs offered to all students.
- Ensure that food handlers promote proper heating, holding, and refrigeration of eggs, meats, and other potentially hazardous foods. Emphasize thorough handwashing after hands become contaminated, and before food preparation and eating.
- Conduct public education programs to in crease the proportion of households in which the principal food preparers routinely refrain from leaving perishable food out of the refrigerator for over 2 hours and wash cutting boards and utensils with soap after contact with raw meat and poultry.

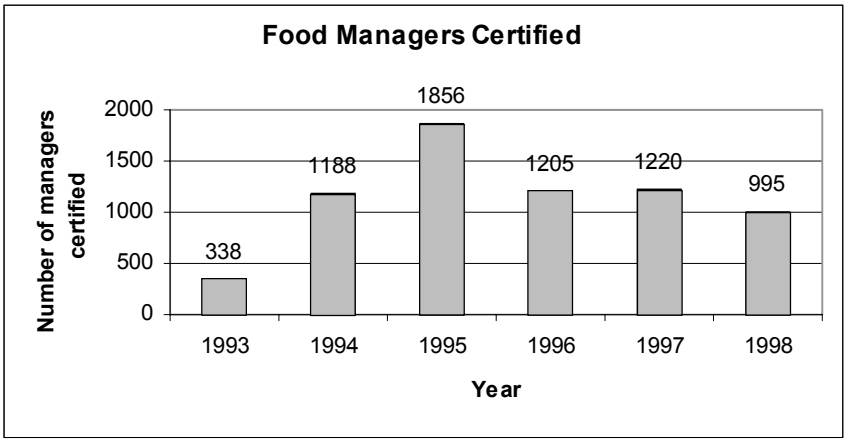
Key Collaborators

>Rhode Island Food Safety Coalition >Hospitality Association >Food Dealers Association >Health Care Facility Association > Elderly and Minority Organizations >University of Rhode Island >RI Department of Education > Johnson and Wales University

By the Numbers



The incidence of salmonella increased slightly from 22.9 per 100,000 people in 1993 to 25 per 100,000 people in 1994 and decreased each year between 1995 and 1998 to 16.1 per 100,000 people.



Between 1993 and 1998, 6,802 individuals were certified.

For More Information Contact

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Progress

Objective 17
Oral Health

Improve oral health by:

- Reducing dental caries (tooth decay) among children;
- Increasing to 85% the proportion of people receiving preventive dental care;
- Increasing the proportion of people insured for dental care;
- Reducing mortality from cancer of the oral cavity and pharynx.

Oral health is an essential and vitally important part of overall health and well-being.

Why It's Important

Oral health affects a person's ability to eat, chew, swallow, and speak, as well as one's self-esteem and ability to learn and work effectively. While many people think of oral health care as a minor aspect of preventive health care because poor oral health is not seen as life threatening, oral diseases and dental neglect can have serious health consequences. Each year, 40-50 Rhode Islanders die from oral and pharyngeal cancer. Most such deaths are preventable. Other health consequences occur when oral infections resulting from bacteria commonly found in the mouth enter the bloodstream and impact major organs of the body. For example, due to the potentially harmful effects of oral bacteria on the heart valves and blood vessels, people with periodontal (gum) disease are at greater risk for experiencing heart problems than those whose gums are healthy. Also, pregnant women with unhealthy gums are at greater risk of delivering babies with low birth weight. Untreated dental decay and infections cause a significant amount of unnecessary lost time from school and work.

Good oral health begins with proper prenatal care and nutrition. With a good start and periodic dental examinations, more people can expect to keep their natural teeth into their senior years. Early identification and treatment of oral disease prevents disability and disfigurement, and reduces or eliminates the cost of subsequent expensive dental treatment and surgery. Access to regular professional oral health services, use of preventive measures such as fluorides and dental sealants, and daily self-care practices are key to ensuring optimal oral health for a lifetime.

What We Have Achieved

Oral health initiatives are advanced in collaboration with key governmental and community partners. These joint endeavors have helped to build the infrastructure that supports efforts to increase provider capacity, especially for vulnerable and underserved populations.

State-level oral health efforts have included two basic approaches: 1) identifying and addressing the oral health needs of school-aged children; and 2) increasing the number of oral health professionals providing treatment to underserved populations of all ages. Under the auspicies of *Healthy Schools! Healthy Kids!*, a collaborative effort of the Rhode Island Departments of Education and Health, a statewide Oral Health Steering Committee was convened to plan for, coordinate, and implement initiatives to improve oral health outcomes for children by expanding school-based and school-linked oral health programs. In the fall of 1999, this Committee developed recommendations to guide oral health initiatives designed to improve access to oral health education and services and to reduce oral health disparities, especially for children from racial or ethnic minorities and those from families with low income.

2010 Notes

With the implementation of new Rules and Regulations for School Health Programs, it is anticipated that school-aged children statewide will benefit from the standardized protocols for dental screenings performed in the school setting. While prevention is most important, only early detection and prompt treatment can limit the complications and expense of untreated oral disease

Several strategies to increase the general dentist capacity for Rhode Islanders with limited access to professional dental services have been implemented including: 1) assessing primary dental care capacity statewide; 2) identifying areas of underservice for designation as dental health professional shortage areas (DHPSAs); and 3) maximizing the eligibility of community sites and providers for a variety of federal and state supported programs that support services for uninsured and underinsured populations. Through the State Loan Repayment Program, the number of dentists and dental hygienists practicing in underserved areas has increased by assisting dental professionals repay educational loans in exchange for a two-year commitment to work in designated shortage areas. Since its inception in 1994, approximately 20% of all participants in the State Loan Repayment Program have been dental professionals. In addition, strong linkages between communities and academic programs have been established to increase the potential recruitment of primary care providers to underserved areas by expanding high quality service-linked training opportunities for students enrolled in a variety of health professional programs, including dental and dental hygiene students, for the mutual benefit of students, communities and vulnerable populations statewide.

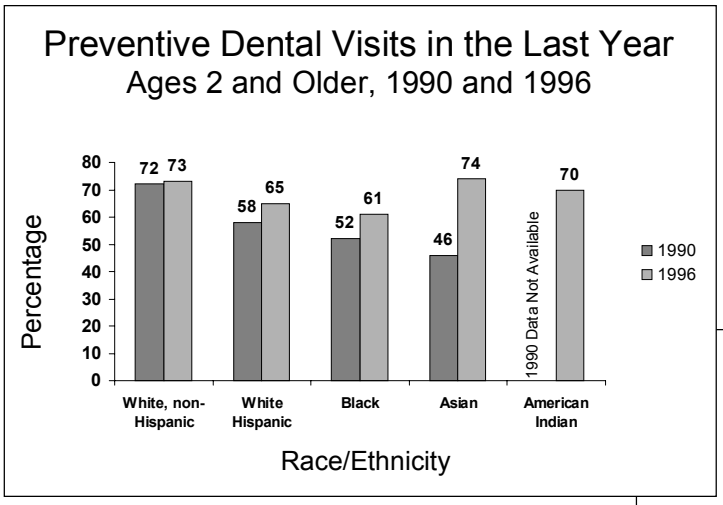
Beyond these broad, statewide activities to increase access to oral health services, efforts to improve the oral health status of Rhode Islanders have included providing technical assistance to community-based dental programs, including school-based dental sealant programs, (e.g. *Providence Smiles)*, community health center dental clinics and hospital-based dental clinics, Travelers Aid, and other programs/organizations serving vulnerable populations.

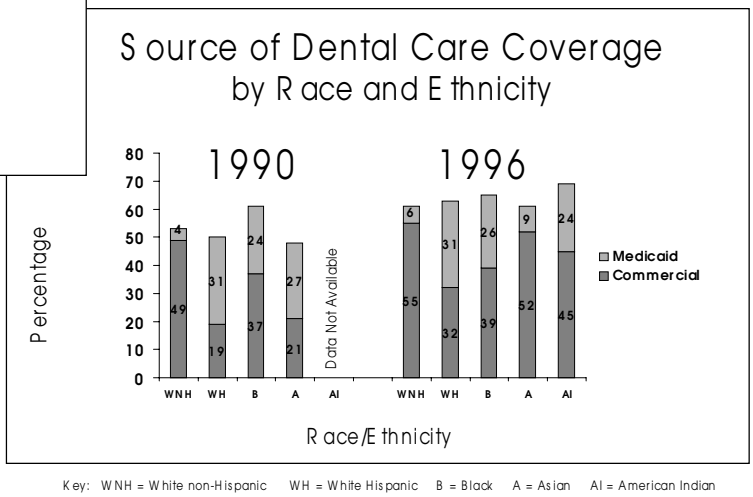
Key Collaborators

>*Healthy Schools! Healthy Kids!* Oral Health Steering Committee >RI Dental Association >RI Dental Hygienists Association >RI Health Center Association >St. Joseph Hospital for Specialty Care >RI Hospital, Samuels Dental Center >RI Department of Human Services >RI Department of Education >RI Department of Corrections >School districts statewide >Federal Bureau of Primary Health Care (BPHC) >BPHC-supported programs & community agencies serving underserved and vulnerable populations >a variety of HEALTH programs and initiatives

By the Numbers

The percent of respondents reporting a preventive dental visit in the last year was greater in 1996 than 1990 for all racial and ethnic groups; while this shows progress in the right direction, it does not meet the target of increasing the proportion of people receiving preventive dental care to 85% (see chart). (Source: 1990 and 1996 RI Health Interview Survey) The percent of respondents reporting some type of dental care coverage increased for all racial and ethnic groups between 1990 and 1996, indicating progress toward increasing the proportion of people insured for dental care (see chart). (Source: 1990 and 1996 RI Health Interview Survey)





Key: WNH = White non-Hispanic WH = White Hispanic B = Black A = Asian AI = American Indian

For More Information Contact

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Progress

Objective 18

Birth Outcomes

Reduce poor birth outcomes by:

- Reducing infant mortality to 6 per 1,000 live births;
- Reducing low birthweight to an incidence of 5% of live births and very low birthweight to 1%;
- Reducing tobacco use by pregnant women to 10% and reducing alcohol and illicit substance use by pregnant women to 5%;
- Increasing the proportion of pregnant women who receive prenatal care in the first trimester to 90%.

The health of an infant at birth will affect the infant's chances of survival beyond age one, and the individual's health throughout life.

Why It's Important

Babies born at weights less than 2,500 grams are at greater risk for death during their first year of life, and for permanent disabilities. The use of tobacco, alcohol, or drugs during pregnancy has been associated with infant deaths, low birthweight, prematurity, and other adverse effects.

Poor birth outcomes can often be prevented if a woman begins prenatal care during the first three months of pregnancy. Starting prenatal care early reduces rates of low birthweight and infant mortality. Improving birth outcomes affects all areas of a child's health and development, and reduces long-term medical costs to family and society.

In 1989, 82% of women began prenatal care during the first three months of pregnancy. However, early prenatal enrollment was lower among poor women and minorities, populations which also have a higher incidence of poor birth outcomes.

What We Have Achieved

Data is critical in the effort to monitor, track and then address factors related to birth outcomes. A system is now in place to collect data regarding demographics, prenatal care, newborn health and developmental risk status on every baby born in a Rhode Island maternity hospital. This data is used to refer infants and families to a home visiting program for family support, public health education including smoking cessation opportunities, and developmental monitoring. In 1996 the home visiting program was expanded to include

prenatal home visiting to establish supports earlier and promote healthy pregnancy and birth outcomes. The newborn data is also used to open a record in KIDSNET, a children's preventive health tracking system, which allows monitoring of public health program participation and health outcomes in the first year of life and beyond.

2010 Notes

KIDSNET will make it possible to link demographic and birth information to infant mortality and other health outcomes as well as to participation in preventive health programs.

The past decade has also been one of tremendous expansion of health care insurance coverage for pregnant women. Eligibility for prenatal care coverage under RIte Care has continued to increase so that currently pregnant women from families with incomes up to 350% of poverty are now eligible. For a family of 3, that is an annual income of $48,580.

Other accomplishments and ongoing activities related to birth outcome include an increase in the number of midwives to support the increase in earlier entry into prenatal care, nutrition education to pregnant women through the WIC program, and passage of legislation and an amendment to the hospital regulations regarding length of maternity stay in hospitals.

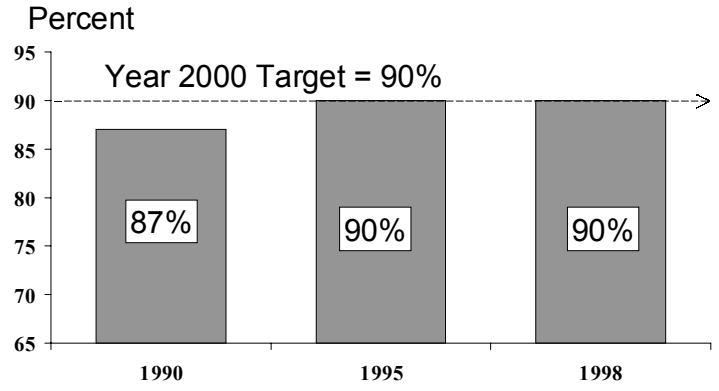
Key Collaborators

>Community Health Centers >Maternity hospitals >RI Chapter, Healthy Mothers, Healthy Babies Coalition >RI Chapter March of Dimes >Project ASSIST >RIte Care >Health Plans >Drug and Alcohol Treatment Programs >Home Health Agencies >Community literacy programs >Community social service agencies

By the Numbers

The percent of women receiving prenatal care in the first trimester has increased. If the provisional data is accurate, it appears that the year 2000 target of 90% has been achieved for the overall population. Although minority populations still fall short of the 90% target, the increases among selected minority populations between 1990 and 1998 have been even more dramatic than among the general population. The data show a 5 percentage point increase among Black women, a 9 percentage point increase for Asian women, and an 18 percentage point increase for Native Americans compared to a 3 percentage point increase for Whites. Because of the association of prenatal care with good birth outcomes, it is hoped that this trend will help reduce the racial disparities in birth outcomes that continue to exist.

PERCENT OF RHODE ISLAND WOMEN WHO RECEIVED PRENATAL CARE IN THE FIRST TRIMESTER*



*1998 data are provisional

Percent Receiving Prenatal Care in First Trimester Among Selected Minority Populations*

	1990	1993	1997
Black	74%	76%	79%
Asian	74%	78%	81%
Native American	63%	75%	84%

*Based on self report, 1997 data are provisional

For More Information Contact

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Progress

Objective 19

High Blood Pressure

Reduce high blood pressure by:

- Increasing to at least 75% the proportion of people with high blood pressure whose blood pressure is under control.

Why It's Important

High blood pressure (hypertension) is defined as blood pressure greater than 140/90 mm Hg, measured on two or more occasions. High blood pressure is more prevalent in middle-aged and elderly people, among people who are obese, smoke cigarettes, drink heavily, women who use oral contraceptives, and people with diabetes, gout and kidney disease. Deaths related to high blood pressure are higher among African Americans than among whites.

High blood pressure is a primary cause of heart disease and stroke, the # 1 and #3 killers in RI and the US.

High blood pressure usually has no symptoms. Once diagnosed, it can be controlled through pharmacological and non-pharmacological (diet, exercise) interventions. Control of high blood pressure has been shown to significantly reduce the risk of cardiovascular disease, stroke and kidney disease, and to decrease the complications of diabetes.

According to the 1997 Rhode Island Behavioral Risk Factor Surveillance System (BRFSS), approximately 22% of adults have been told that they have high blood pressure. This is consistent with national estimates that one-quarter of the adult population has hypertension. In addition, approximately 95% of the adult population have had their blood pressure checked within the past two years, according to the same survey results. The proportion of people in Rhode Island with hypertension who are aware of it, those who are being treated and those who have it under control is often transient. 1988-1991 national estimates reported approximately 70% of the hypertensive population were aware of their high blood pressure, 55% were being treated, and 29% had it under control (NHANES III, Phase 1, 1988-1991). Data from Phase 2 of NHANES III, conducted 1991-1994 (data provided by the Centers for Disease Control and Prevention) found a slight reduction in these numbers with 68.4% aware of their hypertension, 53.6% being treated and 27.4% having their high blood pressure under control. This decrease in hypertension control correlates to the decrease in physical activity levels and increase in weight, two major risk factors for hypertension among Americans over the past few decades.

What We Have Achieved

- The Office of Minority Health within the RI Department of Health has awarded 15 grants to improve education, blood pressure and other cardiovascular health screening rates, and decrease hypertension risk factors (nutrition, physical activity, alcohol intake, weight control) and other health risks related to high blood pressure and cardiovascular disease. The grants went to community-based organizations, churches and other agencies at a grassroots level particularly suited to promote cardiovascular health through education, screenings, and linkages with primary care. Target populations in clude the elderly, women, and children among various minority groups in the state.

- One major program partially funded by HEALTH is the Women & Infants Hospital Family Van, which provides screenings to underserved populations and connects uninsured people to primary care networks. The van makes regular contact with economically disadvantaged communities, targeting its blood pressure and other screenings, education and links with primary care.

- HEALTH was a major collaborator with the American Heart Association for the *Each One Reach One* women's heart disease and stroke prevention education initiative, and collaborated on the development of a community physical activity resource guide.

- The department participated in the formation of the Rhode Island Worksite Wellness Council, whose mission is to promote healthy lifestyles and healthful environments to the working population of the state.

- The department continued its ongoing collaboration with the Rhode Island Prevention Coalition, whose current mission is to decrease the sedentary lifestyle of the adult population in Rhode Island by promoting simple, appealing, enjoyable physical activities of a non-athletic nature, such as walking.

2010 Notes:

Key processes for HEALTH for the coming decade include enhanced surveillance of high blood pressure and other cardiovascular disease risk factors, partnership and collaboration with primary care professionals and consistent, comprehensive health promotion activities to raise awareness and compliance with high blood pressure prevention and treatment.

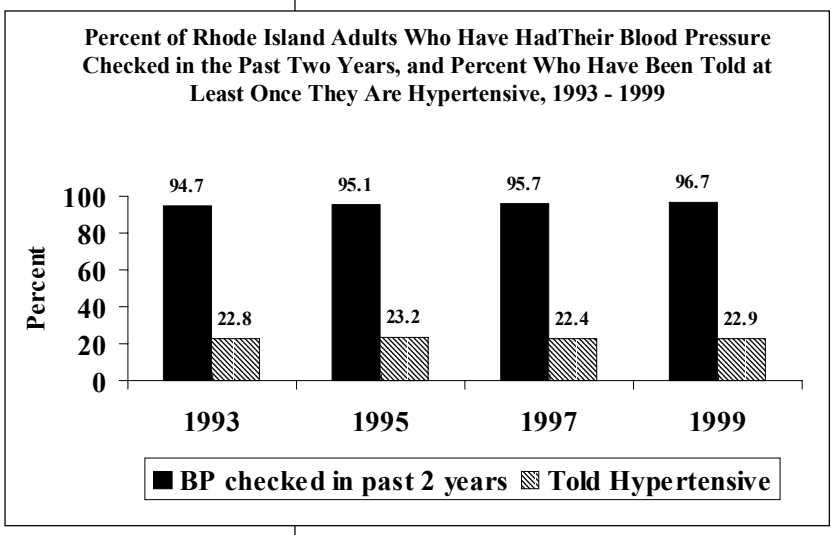
Key Collaborators

>American Heart Association, NE Affiliate >RI Chapter; Diabetes Foundation of Rhode Island >RI Primary Care Physician Advisory Committee >Rhode Island Prevention Coalition >RI Department of Health Office of Minority Health >Memorial Hospital of RI

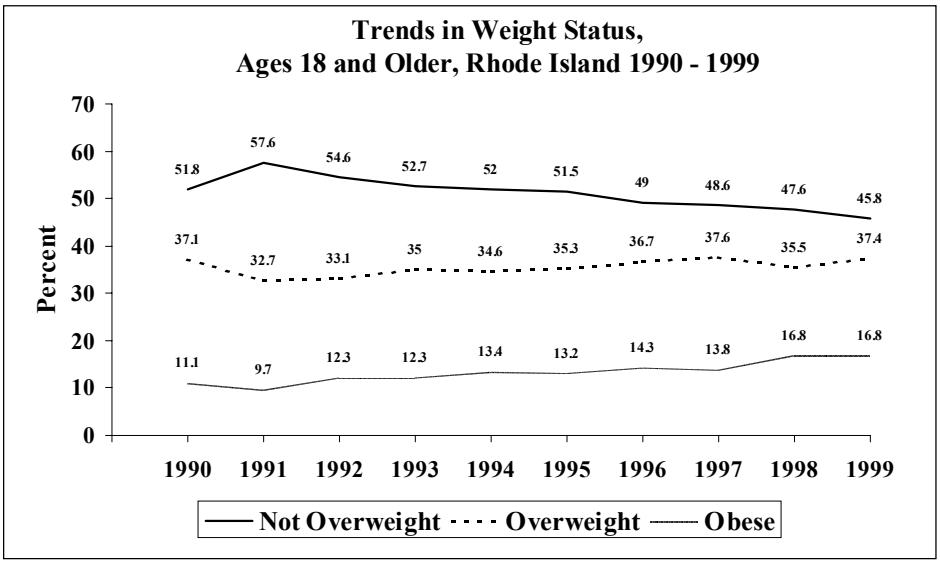
By The Numbers

There is no state surveillance data on the treatment and control of hypertension. However, there is information on the number of persons who have had their blood pressure tested, how many have been told by a medical provider that they have

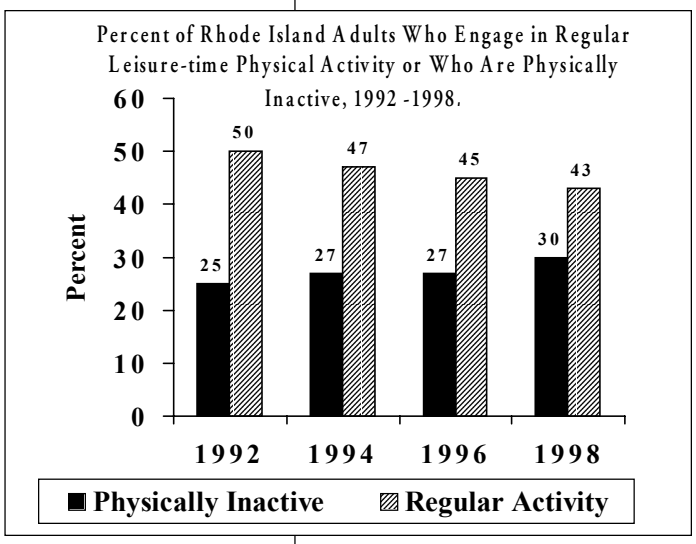
high blood pressure, as well as several of the risk factors for hypertension including weight and physical activity.



Almost all Rhode Island adults have had their blood pressure checked within the past two years, and about 23% of those who have ever had their blood pressure checked have been told they have high blood pressure.



The proportion of Rhode Island adults who are overweight and obese is increasing.



The proportion of Rhode Island adults who do not exercise is increasing.

For more information contact

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Progress

Objective 20

Breast and Cervical Cancer Screening

Increase screening for breast and cervical cancer by:

- Increasing to at least 95% the proportion of women aged 18 and older with uterine cervix who received a Pap test within the preceding one to three years;
- Increasing to at least 90% the proportion of women aged 40 and older who have received a clinical breast examination and a mammogram within the preceding one to two years.

Screening for breast and cervical cancer with regular clinical breast exams, mammograms, and pap smears according to national guidelines will reduce the burden of disease and save lives!

Why It's Important

Each year, almost 800 women in Rhode Island develop breast cancer and another 60 women develop cervical cancer. Furthermore, 200 women every year die from breast cancer and another 17 die from cervical cancer. Overall, Rhode Island has the fourth highest age-adjusted breast cancer death rate in the nation. Breast cancer mortality for black women is 39% higher than among white women in the State. Cervical cancer mortality is over three times higher among black women than among white women.

Encouraging women to obtain regular clinical breast exams, mammograms, and Pap tests, especially among ethnic and racial minority groups, will greatly increase the chances that cancer will be found in early stages. In the case of cervical cancer, the disease may even be prevented through detection in pre-cancerous stages. Therefore, breast and cervical cancer screening will reduce the number of deaths and new cases associated with these diseases.

What We Have Achieved

Funded by a federal grant, the Department with its collaborators administers a statewide Women's Cancer Screening Program (WCSP). The WCSP provides no cost screening tests primarily to low income and uninsured women over age 50. The program further targets eligible women from minority groups, persons with disabilities, and lesbians. Covered services include a women's health exam (a breast and pelvic exam and a Pap test) and a mammogram (breast x-ray). The WCSP also provides follow-up diagnostic testing and referral for treatment, if necessary. Although the program does not pay for treatment, staff is constantly searching for

new sources of low or no cost treatment.

As of May 1999, the WCSP contracts with 58 health care providers, 44 mammography facilities, 16 pathology labs, and 17 medical specialists (e.g., surgeons). Since the fall of 1995, the program has enrolled and screened over 4900 women or about 40% of the estimated population eligible for services. Overall, the WCSP has provided 3,552 free mammograms and 4,475 free Pap tests. These tests resulted in the diagnosis of 22 breast cancers, 17 cervical cancers, and 2 endometrial cancers. All the WCSP women diagnosed with cancer are currently receiving or have received appropriate treatment.

To recruit the remaining 5700 women eligible but not yet participating in the program, the WCSP has launched a statewide outreach effort. In addition, the program maintains contracts with 22 community health centers to promote the annual rescreening and internal recruitment of eligible women in those facilities. In the area of quality assurance, the WCSP engages in professional and public education efforts to increase awareness of screening guidelines. Program staff also works to improve the quality of breast and cervical cancer screening through the on-going review and development of standards, legislation, and clinical practice standards for health care professionals.

2010 Notes

The WCSP is entering a new five-year round of federal funding during which the program will concentrate on recruiting eligible women, coordinating care (tracking and assuring appropriate screening, diagnosis, and treatment) and improving annual rescreening rates. Updated statistics on statewide breast and cervical cancer screening should be available from the Year 2000 BRFSS (Behavior Risk Factor Surveillance System) by May 2001.

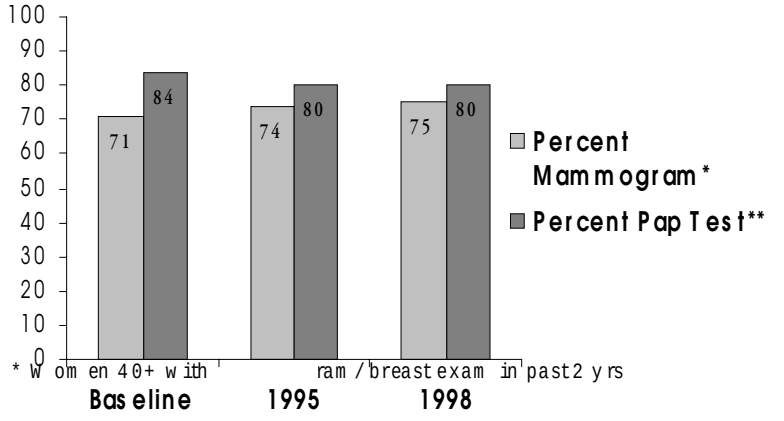
Key Partners Collaborators

>Hospitals >Private health care providers >Radiological and lab facilities >Social service agencies >Community health centers >Medical professional organizations >RI Legislature >State agencies >Senior services >YWCA >Colleges & universities >American Cancer Society >American Association of Retired Persons

By the Numbers

The proportion of Rhode Island women receiving regular breast cancer screening has increased slightly but steadily between 1991 and 1998, whereas the proportion receiving regular cervical cancer screening has actually declined. The target for neither objective has been achieved.

Percent Receiving Breast/Cervical Cancer Screening Among Rhode Island Women, 1991-1998



* Women 40+ with mammogram/breast exam in past 2 yrs

** Women 18+ with Pap test in past 3 yrs

Percent Receiving Breast/Cervical Cancer Screening Among Rhode Island Women by Race/Ethnicity,* 1996

	White	Black	Hispanic	State
Mammogram/ Breast Exam (last 2 years)	75	74	75	75
Pap Test (last 3 years)	77	83	86	77

* The table displays the racial/ethnic groups for which there was a sufficient number of statewide survey respondents to determine accurate proportions.

For More Information Contact

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Progress

Objective 21

HIV Prevalence

Limit the prevalence of HIV infection to:

- No more than 400 per 100,000 people in 2000, from 229 per 100,000 people in 1999.

Why It's Important

HIV infection is a serious concern because of the fatal outcome of AIDS. The prevalence of HIV infection continues to increase in Rhode Island as improved treatments make this disease a chronic condition. This means that more people living with HIV are in need of a variety of health and human services. While trends show a slight decline in the number of new HIV infections in Rhode Island, there has been a shift in the risk behaviors associated with new HIV infections. For example, injecting drug users and heterosexuals are equally at risk for HIV as men who have sex with men. There is also growing concern over the impact of HIV infections on minority women and the rising proportion of heterosexual transmissions.

More people living with HIV are in need of a variety of health and human services. There is also growing concern over the impact of HIV infections on minority women and the rising proportion of heterosexual transmissions.

What We Have Achieved

From 1993 to 1999, the annual incidence of new AIDS cases in Rhode Island decreased 70% (from 295 cases in 1993 to 87 cases in 1999). This decline has occurred in both genders, all age groups, and across all major racial groups in the state. During this time the prevalence of AIDS, which is the number of people living with the disease in the state, has increased 70% (from 506 living cases in 1993 to 860 living cases in 1999), largely as a result of improved medical treatments. While HIV surveillance in Rhode Island has been based on the number of positive HIV tests and not the number of HIV cases, similar trends have appeared. From 1993 to 1999, the number of positive HIV tests reported decreased 31% (from 324 in 1993 to 224 in 1999). As with AIDS, the introduction of new treatments appears to be extending the length of time people live with the HIV, thereby causing an increase in the prevalence of HIV in Rhode Island. To deal with the rising prevalence of HIV and AIDS, an array of outreach and support programs have been implemented.

- Outreach efforts have been enhanced to facilitate high-risk populations use of HIV prevention counseling, HIV testing and partner notification services.
- Thirteen community-based programs were awarded HIV prevention grants to address the needs of the populations and risk behaviors identified by the Rhode Island Community Planning Group.
- Over 500 staff at 50 community-based agencies have participated in a variety of capacity building programs that will enhance their agencies ability to provide and evaluate HIV prevention services
- Supplemental programs have been funded by the Centers of Disease Control and Prevention (CDC) to address the HIV Prevention needs in communities of color.
- The syringe exchange program has expanded the number of sites and substance abuse counseling services.
- A faith-based HIV prevention curriculum for youth has been developed with African-American churches.
- Collaborations with the Department of Education and the Department of Children, Youth and Families have enhanced efforts to involve youth in the community planning process.
- Cooperation with the Division of Substance Abuse has strengthened efforts to reach injecting drug users with HIV Prevention services.

2010 Notes

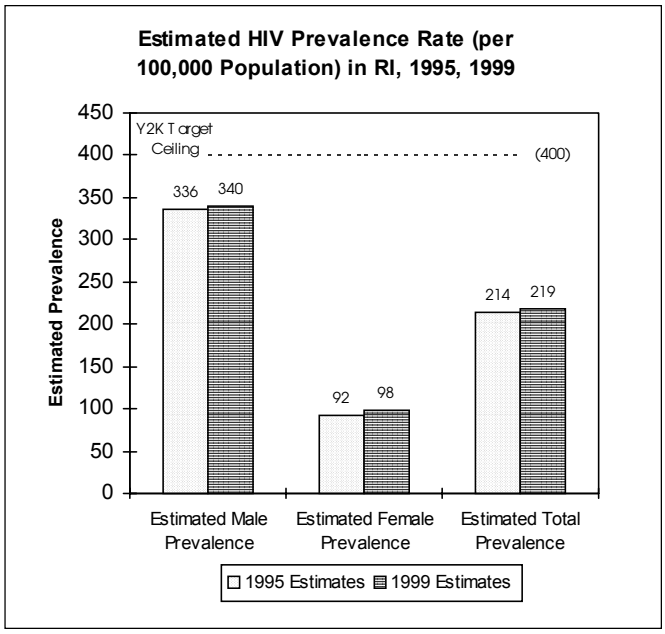
The Office of HIV/AIDS must continue to monitor trends and anticipate the needs of people engaging in high-risk behaviors.

- Provide linguistically appropriate and culturally sensitive interventions.
- Focus interventions on youth, high-risk women and their children, communities of color, men who have sex with men, and injecting drug users and their sexual partners.
- Encourage women to test for HIV before becoming pregnant.
- Study the roles that domestic violence, substance abuse and sexual abuse play in HIV transmission to support development of more effective interventions.
- Alter HIV counseling, testing and referral mechanisms in the state to better target high-risk populations for HIV testing.

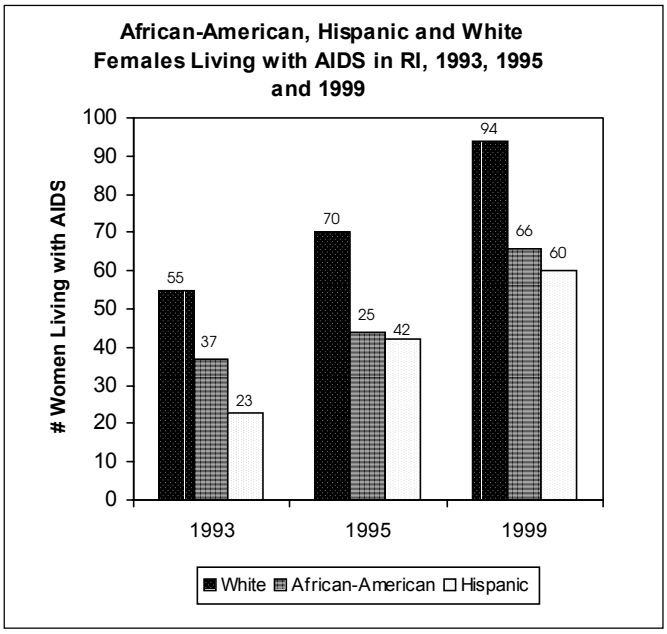
Key Collaborators

>RI Department of Education >RI Department of Human Services >RI Department of Children, Youth & Families >RI Department of Corrections >Health Resources Services Administration >Health Care Finance Administration >U.S. Department of Health and Human Services, Region One, Office for Minority Health >The Community Planning Group >The medical community >AIDS advocates >Community-based organizations >Centers for Disease Control and Prevention

By the Numbers



From 1989-1999 HIV surveillance in RI relied entirely on HIV+ test results, not cases. Therefore, estimates of HIV prevalence are calculated using both state and national data. The above graph illustrates the increase in estimated HIV prevalence rates for all of RI and for males and females in the state from 1995 to 1998.



As the HIV epidemic has progressed, minority populations, particularly minority females, have accounted for an increasing number and proportion of people living with the disease.

For More Information Contact

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Progress

Objective 22

Infectious Diseases

Reduce the risk to the public of existing and emerging communicable diseases by:

- Decreasing the tuberculosis rate to 3.5 cases per 100,000 persons per year;
- Decreasing the Lyme disease rate to 20 cases per 100,000 persons per year;
- Increasing pet rabies vaccination rates to 90% for cats and 99% for dogs.

Once expected to be eliminated, emerging and re-emerging infectious diseases, as well as drug resistant organisms, pose a growing threat and remain a leading cause of illness and death in Rhode Island.

Why It's Important

Tuberculosis (TB) is a serious bacterial infection of the lungs spread by airborne droplets which can result in death if untreated. Particularly worrisome is the emergence of multi-drug resistant TB strains which remain infectious for longer periods of time. In this decade, the proportion of TB cases in persons who are immigrants from foreign countries (where TB is highly prevalent) has grown, while the proportion of disease in US-born persons has decreased. Aggressive case finding and treatment to cure active cases are strategies to control TB.

Lyme disease is a bacterial infection transmitted by the deer tick commonly found in our deciduous woodlands. It is characterized by fever and a red "bull's eye" rash on the skin. When Lyme disease is not treated properly and early, chronic joint, heart, and neurological disease can develop. Prevention measures include wearing protective clothing, using insect repellent containing DEET, and performing tick checks and removal after outdoor activities where deer ticks are present. In recent years (1995-1998) an expansion of deer tick populations northward has been observed in Rhode Island. A Lyme disease vaccine was licensed for commercial use in 1999. It is too early to assess any preventive benefits yet.

In 1994, a new strain of raccoon-adapted rabies virus invaded Rhode Island's wildlife population (mainly raccoons, skunks, foxes, and woodchucks). In prior years bat rabies had been the only strain of concern. Rabies is a virus infection of the brain which is always fatal in humans. Rabies is transmitted to humans via exposure to the virus in the saliva of an infected animal. Prevention of rabies in-

cludes pet vaccination, avoidance of contact with wild and stray animals (including bats), and passive and active immunization in the event of exposure.

What We Have Achieved

A universal directly observed therapy (DOT) program is utilized to ensure that people with TB adhere to the complex and lengthy treatment regimens. The DOT Program Outreach Workers who are matched linguistically and culturally (English, Spanish, Portuguese, Cambodian, Thai, Hmong, Cape Verdean) to the TB cases for the full course of treatment provide a wide range of medical and social case management services. In 1998, 57% of the sixty-three cases of TB in Rhode Island were foreign-born individuals, representing sixteen countries. The case completion rate for TB medication was 97.3%.

2010 Notes

In future years, the pet vaccination objective will be replaced by percent of people over age 65 who receive an influenza vaccine.

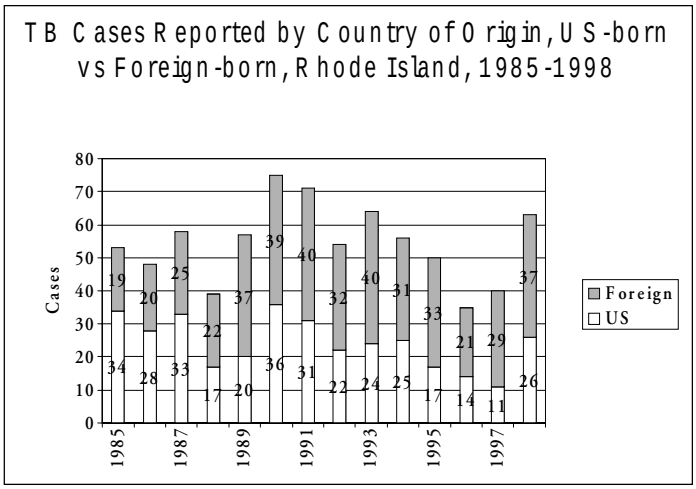
Successful community partnerships to prevent Lyme disease include a collaborative project with the University of Rhode Island's Center for Vector-Borne Disease to study the geographic distribution of ticks and their migration, and physician and other professionals' training in Lyme disease diagnosis, treatment, and reporting. The appropriate recognition and diagnosis of Lyme disease has greatly improved in the State, as demonstrated by an increase in reported cases from 100 cases in 1990, to 789 cases in 1998. In 1998-99, a clinical guide was sent to all pediatricians to review Lyme disease diagnosis and treatment. Informational pamphlets have been distributed throughout the State, and the HEALTH Web site contains Lyme disease prevention materials.

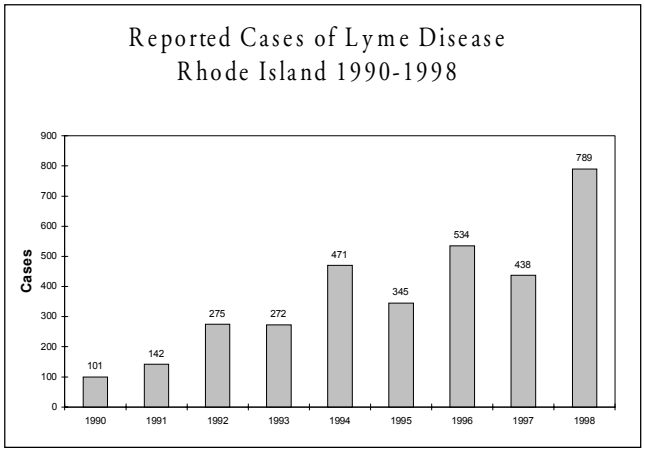
In 1994 the Governor's Rabies Prevention Task Force (a multidisciplinary team of public and private stakeholders) was established and launched a massive public education campaign. Action messages included " VACCINATE YOUR PETS—RABIES KILLS," "DON'T TOUCH OR FEED WILDLIFE OR STRAYS—RABIES KILLS." A school curriculum was developed and nurse-teachers trained to implement age-appropriate school based educational efforts. HEALTH established a rabies control unit with 24 hour/day reporting and medical case management for all reported animal bites to humans. Rabies vaccine repositories were established at area hospitals so that prompt access to this scarce and expensive product was possible for victims. Personnel likely to experience animal bites in the course of their work (animal control officers, wildlife conservation officers, etc.) received pre-exposure immunizations. Enforcement of animal control and quarantine measures increased. The RI Veterinary Medical Association sponsors low-cost pet vaccination clinics regularly.

Key Collaborators

>Roger Williams Medical Center TB Clinic >TB Advisory Committee >Emerging Pathogens Advisory Committee >Community-based home health agencies >Hasbro Children's Hospital >Infection control practitioners >Centers for Disease Control and Prevention >University of Rhode Island Center for Vector-borne Disease >Rhode Island physicians/hospitals/laboratories >School nurse-teachers >South County Hospital >University of Rhode Island >RI Department of Environmental Management >RI Veterinary Medical Association >City/town animal control officers >Animal shelters >RI Department of Environmental Management

By the Numbers





1. Trends in TB Cases

The annual TB case - rate declined in the mid-1990s and has increased slightly in recent years. The majority of TB cases have been reported among foreign-born individuals. The Year 2000 Objective of 3.5 cases per 100,000 persons per year has not been met because Rhode Island's population is constantly refreshed by immigration from countries where TB is highly prevalent. Most of the cases are concentrated in Providence and immediate surroundings. The annual case rate for Providence, 15 per 100,000 population, has been 5 times the average annual aggregate for the entire rest of the state (3 per 100,000 population).

2. Lyme Disease Rates

State-wide Lyme disease rates have increased during the 1990s, hitting a new high in 1998 with a rate of 79.2 case per 100,000 population. The majority of cases are found in Washington County. The increase in Lyme disease case rates is likely a result of improved physician diagnosis and reporting and an observed northward spread of the deer ticks that carry Lyme disease.

3. Rabies

A telephone survey of households in 1995 found pet vaccination rates were high at 85% for cats and 95% for dogs. Annually, we case manage 1000 to 1200 animal bite reports, and on average 100 persons receive rabies post-exposure prophylaxis. The lab tests on average 600 animals, and 6000 pets are quarantined at city pounds or at home.

For More Information Contact

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Progress

Objective 23

Immunization

Increase the basic immunization series among children under age two to:

- At least 90%.

Why It's Important

While some preventable infectious diseases are slowly being eradicated, others are on the rise. Young children are at high risk for serious complications from these diseases. By immunizing children we can protect them.

Many families have never seen these diseases, and are often unaware of the consequences that can occur, such as pneumonia, brain damage, blindness, severe skin scarring, physical handicaps, and even death.

In July, 1998, approximately 16% of two-year-old children in Rhode Island had not received a complete immunization series for measles, mumps, and rubella/German Measles (MMR); diphtheria, tetanus, and pertussis/whooping cough (DTP); polio; and Haemophilus influenza type B. Twelve percent had not been immunized against hepatitis B, and 67% were not immunized against varicella/chicken pox. These children are at risk for developing these diseases and for infecting others.

Since increased levels of immunization have decreased the incidence of disease over the last 20 years, many families have never seen these diseases, and are often unaware of the consequences that can occur, such as pneumonia, brain damage, blindness, severe skin scarring, physical handicaps, and even death.

What We Have Achieved

Immunization coverage is improving, and the rate of disease is declining. The Department of Health has developed a multi-faceted approach for continued improvement in immunization rates in young children.

- Funded partly by a surcharge on health insurance premiums, financial barriers have been eliminated through the Universal Vaccine Distribution program. This provides free vaccine to medical providers for all children through the age of 18. Two walk-in sites provide free immunizations and follow-up services, and community health centers do not charge shot administration fees to the under-insured.
- Medical providers are able to access information about a child's immunization

2010 Notes

Two major changes are affecting the efforts to fully immunize young children. One is the rapid advances in vaccines, both the development of new vaccines and combinations of long standing individual vaccines. The other is the changing face of Rhode Island's population, with many children arriving from other countries without an immunization record or a complete immunization series.

The advances in vaccine mean greater potential than ever for eradicating vaccine preventable disease in this country. However, the new and combined vaccines are much more costly. In order for Rhode Island to remain a universal purchase and distribution state, it is likely new sources of funding will need to be pursued.

The Department of Health will also continue to develop strategies for identifying and reaching children who are under-immunized. The completion of the KIDS NET registry system and strong partnerships with managed care entities and health, minority and other community organizations are key elements in the process, as well a strong outreach and education component.

history through KIDS NET, a statewide immunization registry.

- Increased immunization assessment activities in health centers, schools, preschools and day care sites, and collaborations with managed care partners for quality improvement have helped to identify pockets of under-immunized children and opportunities for improvement in immunization services.
- Outreach and education services are targeted to families who reside in pockets of need or who are considered "hard to reach," and are provided by multi-lingual staff with the assistance of Parent Consultants who serve as liaisons to the communities.
- Partnerships with the Rhode Island Rotary Clubs, school administrations, and school based health centers have improved outreach and education services to parents and provided opportunities for in-school "catch-up" immunizations.
- Professional education for providers regarding new vaccines, immunization schedules, regulations, and vaccine management is ongoing through satellite downlink courses, site visits, web site and fax information, and printed materials.
- New surveillance sites at schools and aggressive follow-up of individuals diagnosed with vaccine preventable diseases, and their contacts, are parts of the efforts for disease prevention in the state.
- Strong partnerships with school nurse-teachers, day care providers, the medical community, the Minority Health Coalition and the wide variety of members of the statewide Immunization Action Coalition enhance efforts to ensure a comprehensive, inclusive and proactive program.

Key Collaborators

>Immunization Action Coalition >School nurse teachers >Health care insurers >Health care providers >Community health centers >School administrators >Day care and pre-schools >Managed care organizations >RI Chapter, American Academy of Pediatrics >WIC sites >Hasbro Children's Hospital >St. Joseph

Hospital for Specialty Care >Travelers Aid >Rotary International >March of Dimes >American Academy of Family Practitioners, RI Chapter >Minority Health Coalition

By the Numbers

The advances in vaccine mean greater potential than ever for eradicating vaccine preventable disease in this country. However, the new and combined vaccines are much more costly. In order for Rhode Island to remain a universal purchase and distribution state, it is likely new sources of funding will need to be pursued.

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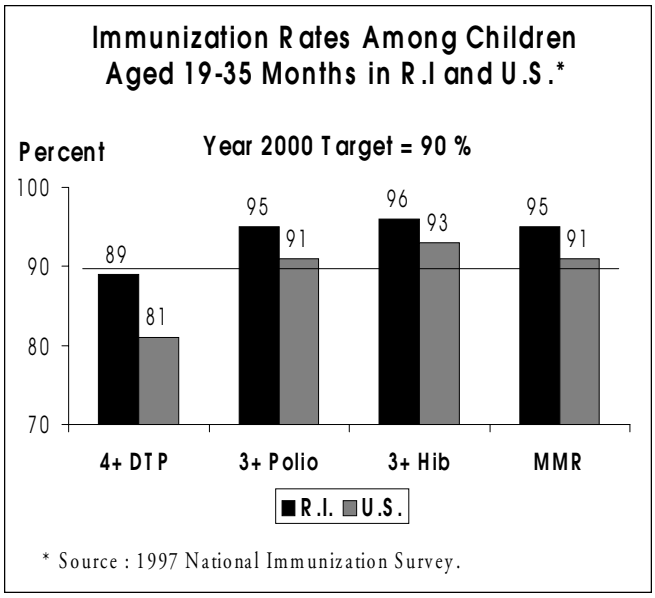

* Source : 1997 National Immunization Survey.

Reported Vaccine-Preventable Disease All Ages, 1993-1998

Year	1993	1994	1995	1996	1997	1998
Diphtheria	-	-	-	-	-	-
H influenzae*	2	1	5	2	4	9
Hepatitis B	19	8	10	19	22	75
Measles	2	7	6	1	-	-
Mumps	2	4	1	1	8	1
Pertussis	14	8	7	41	19	20
Polio	-	-	-	-	-	-
Rubella	1	3	-	-	-	1
Varicella**	2668	1654	1072	669	474	275

* All serotype.
** Sentinel reporting.
Source : Immunization Program, RI Department of Health.

For More Information Contact

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Progress

Objective 24

Primary Care

Increase primary care access by:

- Increasing the proportion of people who have a specific source of ongoing primary care to at least 95%.

Why It's Important

Access to primary care provides important opportunities for disease prevention and health promotion as well as the early detection of disease.

Primary care is the provision of coordinated, comprehensive, continuous health care services that focus on the prevention and early detection of disease and on the maintenance of health. Primary care provides critical linkages between the individual, the community, and public health. With an emphasis on services that are culturally sensitive and community responsive, primary care is an essential entry point to other appropriate health care. Access to primary care is influenced by a number of factors including health insurance status, and the number and distribution of primary care clinicians.

In 1998, about 10% of Rhode Islanders had no health care insurance, the single most important barrier to ongoing quality primary care. The poor and minorities are particularly likely to be uninsured or underinsured, have no reliable source of primary care, and/or encounter barriers when they enter the health care system. Even for individuals who are insured, many are not covered for essential primary care services such as nutrition counseling, smoking cessation, or routine screening tests. The Year 2000 objectives for clinical preventive services, and the reduction in health status disparities among minorities, cannot be achieved without assuring that all Rhode Islanders have access to affordable, high quality primary care.

What We Have Achieved

The Office of Primary Care (OPC) maintains a broad complement of community and governmental partners with which we work to improve the quality and availability of primary care throughout the State. OPC provides technical assistance to our partners on a variety of issues, e.g., JCAHO Ambulatory Care Accreditation, grant writing, data requests, etc.

OPC established and provides ongoing support to the Primary Care Physician Advisory Committee — a group charged with advising HEALTH on programmatic and policy issues affecting primary care throughout Rhode Island.

OPC conducted a statewide survey of health care professionals to measure primary care capacity throughout the State. Survey results were used to expand the number of provider sites eligible to participate in a variety of (Federal) Bureau of Primary Health Care-supported programs targeted to underserved and vulnerable populations.

OPC maintains State operations for the National Health Service Corp Scholarship and Health Professional Loan Repayment Programs and assists with the recruitment and retention of primary care providers in underserved areas throughout Rhode Island.

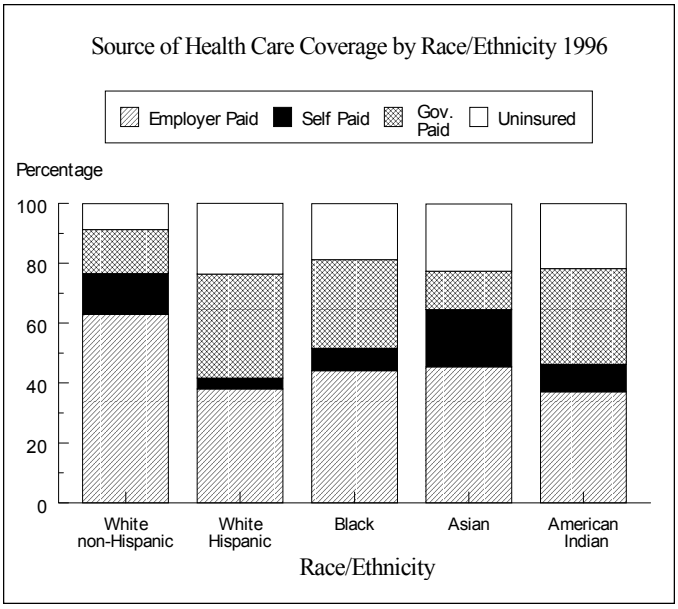
2010 Notes

It is anticipated that new 'usual source of primary care' data from the 2000 HIS (Health Interview Survey) will be available in 2001.

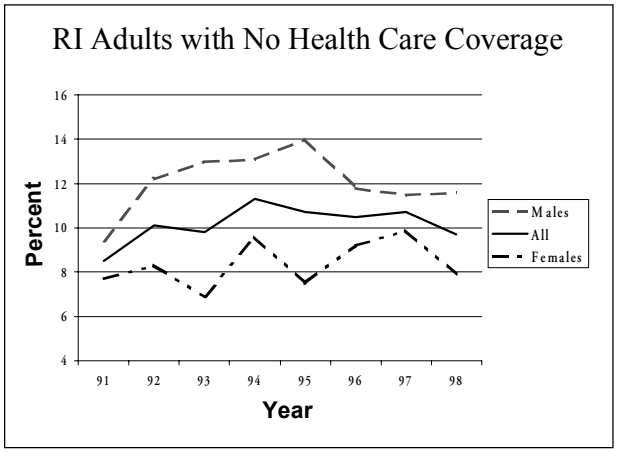
Key Collaborators

>Community health centers & the RI Health Center Association >Primary Care Physician Advisory Committee >Practicing primary care clinicians >RI Departments of Human Services & Education >Brown University School of Medicine >RI Medical Society & other health professional organizations >Federal Bureau of Primary Health Care (BPHC) >BPHC-supported programs & community agencies serving under- served and vulnerable populations >a variety of HEALTH programs and initiatives

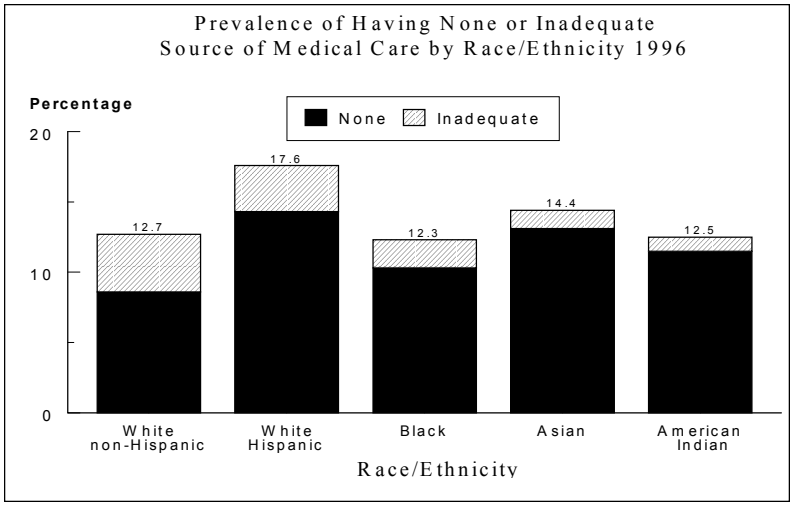
By the Numbers



Racial and ethnic minority populations experience much lower rates of overall and employer-paid health insurance coverage than whites.



From 1991 to 1998 the percentage of uninsured remained relatively stable at around 10% of the population.



For More Information Contact

Mary Anne Miller, Chief, HEALTH, Division of Disease Prevention and Control; telephone: (401) 222-1171; e-mail: MaryanneM@doh.state.ri.us

Progress

Objective 25

Activity Limitations

Reduce limitations as a result of chronic conditions and disabilities by:

- Reducing the proportion of people who experience a major activity limitation to less than 10% (Baseline: 11.5% in 1985);
- Ensuring access both in delivery of services and physical environment (compliance with the Americans with Disabilities Act) for people with chronic conditions or disabilities, so they can readily utilize prevention and intervention services.

Based on the 1996 Rhode Island Health Interview Survey there are 130,000 Rhode Islanders who have a major activity limitation.

Why It's Important

Rhode Islanders with acute or chronic health conditions comprise a significant proportion of the state's population. There are 130,000 Rhode Islanders with a major activity limitation due to a disabling condition. An additional 30,000 have a disabling condition that results in some activity limitation. These individuals are at-risk for a reduction in their overall functioning due to their disability. Further they are at-risk for secondary conditions which occur in conjunction with a primary disability. The Centers for Disease Control and Prevention estimates that the prevalence of activity limitations or disability will likely increase by about 50% by the year 2010 due to overall increased survival and life expectancy among young and aging population, thanks to public health successes in preventing premature death and improved medical and assistive technology.

What We Have Achieved

- Established the Disability and Health Program (DHP) through funding from the Centers for Disease Control and Prevention. The focus of the DHP is to build public health capacity in the state to promote the health and wellness of people with disabilities.
- Established a population-based surveillance system for people with disabilities.
- Established a statewide registry for Rhode Islanders who have sustained a traumatic brain injury (TBI). Also, the DHP won a three-year grant from the Centers for Disease Control to improve its data collection for people with TBI.

- Provided ongoing training of health care professionals in order to increase the capacity of primary health care providers to serve people with disabilities and train people with disabilities to be better consumers of health care.
- Collaborated with state and community-based agencies to develop more effective services for people with disabilities, including the Statewide Transition Council and the Assistive Technology Advisory partnership.
- Worked to increase the number of health promotion programs that include people with disabilities as a specific target group.

2010 Notes

The Department of Health will have two years of population-based data for Rhode Islanders with disabilities in 2000. This information will greatly assist policy makers in identifying state specific health objectives. Further, the national Healthy People 2010 Objectives has a specific chapter on Disabilities and Secondary Conditions as one of the twenty-six chapters. The goal of this chapter is to promote health and prevent secondary conditions among persons with disabilities, including eliminating disparities between persons with disabilities and the U.S. population.

Key Collaborators

>State and community-based organizations providing services to people with disabilities and their families >Brown University Population Studies and Training Center >Primary health care providers >Centers for Disease Control and Prevention

By the Numbers

The proportion of Rhode Islanders with a major activity limitation has increased over a ten-year period. The prevalence of a major activity limitation in Rhode Island is higher than the national average for both time periods. The target for Y2000 has not been achieved.

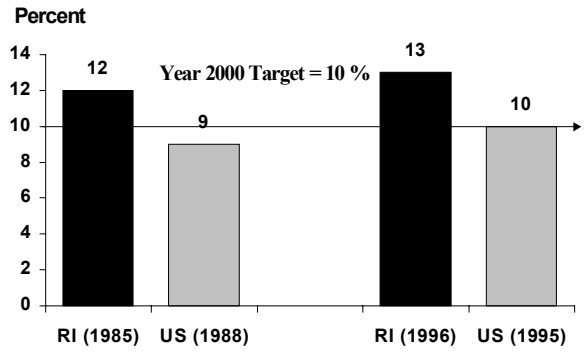
People with disabilities do not utilize routine health care to the extent that people without disabilities, despite having similar levels of health coverage. Utilization and access of preventive dental care is significantly lower for people with disabilities compared to people without disabilities.

Health Care Access and Utilization, by Disability Status, Rhode Island, 1996

	Persons with Disabilities*	Persons without Disabilities
• Routine Physician Visits in past 12 months	69 %	72 %
• Preventive Dental Visits in past 12 months	52 %	75 %
• Health Care Coverage	90 %	90 %
• Dental Care Coverage	49 %	63 %
• Regular Source of Care	90 %	87 %

* Defined as Persons who have major activity limitations.
Source : 1996 Rhode Island Health Interview Survey.

Prevalence of Major Activity Limitations, Rhode Island and United States



Source : 1985 and 1996 RI Health Interview Surveys for RI.
1988 and 1995 National Health Interview Surveys for the US.

For More Information Contact

David Hamel, Program Manager, HEALTH, Disability and Health Program; telephone: (401) 222-4632; e-mail: DaveH@doh.state.ri.us

Healthy Rhode Islanders 2000

Progress Review

Appendices

Appendix A, Contributors 1

Lead Persons
for the 25 Progress Review Statements

Objective	Division	Lead Person
1. Physical Activity	Disease Prevention & Control	Andrea Vastis
2. Nutrition	Disease Prevention & Control	Kathleen Cullinen
3. Tobacco Use	Disease Prevention & Control	Carol Hall-Walker
4. Alcohol & Other Drug Related Deaths	Mental Health, Retardation & Hospitals	Sheila Whalen
5. Unintended Pregnancies	Family Health	Jan Shedd
6. Suicide/Injurious Suicide Attempts	Disease Prevention & Control	Beatriz Perez
7. Mental Disorders	Mental Health, Retardation & Hospitals	Paul Carvisiglia
8. Homicides and Assault Injuries	Disease Prevention & Control	Beatriz Perez
9. School Health Education	Disease Prevention & Control	Ann Thacher
10. Unintentional Injuries	Disease Prevention & Control	Nancy Libby-Fisher
11. Work-Related Diseases and Injuries	Environmental Health	Edward Arcand
12. Children's Blood Lead Levels	Family Health	Magaly Angeloni
13. Environmental Tobacco Smoke	Environmental Health	Robert Vanderslice
14. Radon	Environmental Health	Edward Arcand
15. Drinking Water Quality	Environmental Health	June Swallow
16. Foodborne Pathogens	Environmental Health	Ronald Lee
17. Oral Health	Disease Prevention & Control	Maureen Ross
18. Birth Outcomes	Family Health	Ellen Amore/Sam Viner Brown
19. High Blood Pressure	Disease Prevention & Control	Andrea Vastis
20. Breast & Cervical Cancer	Disease Prevention & Control	Donald Perry
21. HIV Prevalence	Disease Prevention & Control	Paul Loberti
22. Infectious Diseases	Disease Prevention & Control	Thomas Bertrand
23. Immunization	Family Health	Susan Shepardson
24. Primary Care	Disease Prevention & Control	Mary Anne Miller
25. Activity Limitations	Family Health	David Hamel

Appendix A, Contributors 2

Community Review and Comment Process
for the 25 Health Objectives

Health Objectives	Community Review and Comment Participants
1. Physical Activity	Health Plans, Insurance Companies, Hospitals, Voluntary Health Agencies, Colleges & Universities, Cities & Town Parks and Recreation, RI Department of Transportation, YMCA and YWCA networks, Community-based organizations, Senior-service agencies
2. Nutrition	Kids First (USDA Team Nutrition Program), Public and private schools, RI Department for Children, Youth, and their Families, RI Department of Education, RI Nutrition Hotline and Information Center, RI WIC Program, School food service vendors, Johnson & Wales University, Memorial Hospital of RI, Miriam Hospital of RI, New England Dairy & Food Council, Nutrition Advisory Forum, Rhode Island Hospital, University of Rhode Island, Women and Infants Hospital
3. Tobacco Use	Rhode Island Tobacco Control Coalition, American Cancer Society, RI Affiliate, American Lung Association, RI Affiliate, American Heart Association, RI Affiliate, Substance Abuse Prevention Task Forces, Urban League of Rhode Island, RI Pharmacy Foundation, March of Dimes of Rhode Island, RI Department of Education, RI Dental Association, RI Parks and Recreation Association, American Academy of Pediatrics, RI Chapter, RI Indian Council, Progresso Latino, Initiatives for Human Development, Mayor's Council on Drug and Alcohol Abuse, RI Council on Alcoholism and Other Drug Dependence, The Carriage House, Socio-Economic Development Center for Southeast Asians, Rhode Island Cancer Council, University of Rhode Island, Cancer Prevention Center, Rhode Island Hospital, Roger Williams Hospital, RI Parent Teacher Association, Miriam Hospital, Veteran's Medical Center, N.A.A.C.P.

Health Objectives	Community Review and Comment Participants
4. Alcohol & Other Drug Related Deaths	Governor's Office on Highway Safety, North Charles Research and Planning Group, Drug & Alcohol Treatment Association, RI Cares, Council of Mental Health Centers, State Agencies, Municipal Police Departments and Task Forces, Mothers Against Drunk Drivers, Centers for Substance Abuse Prevention and Treatment, Office of National Control Policy, Brown University Center for Alcohol and Addictions Studies, University of Rhode Island
5. Unintended Pregnancies	Funded Health Care Agencies, Health Plans, State Agencies, Schools, Private Physicians, Community-Based Organizations
6. Suicide/Injurious Suicide Attempts	The Samaritans, the Mental Health Association, Council of Community Mental Health Centers, Department of Education, Department of Mental Health, Retardation, and Hospitals, Department of Children Youth and Families, Northeast Injury Prevention Network, Education Development Center, and the Children's Safety Network
7. Mental Disorders	RI Department of Mental Health, Retardation and Hospitals, Division of Integrated Mental Health Services, Department of Children, Youth & Families, Department of Elderly Affairs, Community Mental Health Centers, Eleanor Slater Hospital, Community Hospitals, Mental Health Consumer Advocates, Alliance for the Mentally Ill, Governor's Council on Mental Health, Mental Health Advocates Office
8. Homicides and Assault Injuries	Brown University, RI Employee Assistance Program, University of Rhode Island Family Violence Research Program, Office of the Attorney General, RI Medical Society, Office of the Medical Examiner, Joint Legislative Commission to Study Women's Health Issues, Hospitals and health care providers, Batterers intervention programs, Department of Education, Department of Mental Health, Retardation, and Hospitals, Department of Children, Youth and Families, Sexual Assault & Trauma Resource Center, and RI Anti-Violence Coalition

Health Objectives	Community Review and Comment Participants
9. School Health Education	The School Health Advisory Committee (SHAC) includes over 100 members from local schools and districts including teachers, administrators, school nurse teachers, counselors, facilities managers, parents, community based organizations, State agencies and statewide advocacy and practice groups
10. Unintentional Injuries	The Governor's Office on Highway Safety, RI Department of Transportation, RI Department of Education, RI Department of Human Services, Rhode Island SAFEKIDS Coalition, Municipal Police Departments, Local School Departments
11. Work-Related Disease and Injuries	U.S. Department of Labor, OSHA, Rhode Island Committee on Occupational Safety and Health, Rhode Island Department of Environmental Management, Rhode Island Department of Labor and Training, American Lung Association of Rhode Island, Rhode Island Safety Association, Rhode Island Association of Builders, Insurance companies, Business/trade associations
12. Children's Blood Lead Levels	Department of Children, Youth and Families, Department of Human Services, Attorney General's Office, Department of Environmental Management, City of East Providence, Rhode Island Housing, Community health centers, Hospital-based clinics, Private physicians, commercial laboratories, Local housing enforcement authorities and Court Systems, Health Insurance companies, Licensed contractors and inspectors, Community-based agencies, School Departments, Early childhood education agencies, Community organizations

Health Objectives	Community Review and Comment Participants
13. Environmental Tobacco Smoke	Rhode Island Tobacco Control Coalition, American Cancer Society, RI Affiliate, American Lung Association, RI Affiliate, American Heart Association, RI Affiliate, Substance Abuse Prevention Task Forces, Urban League of Rhode Island, RI Pharmacy Foundation, March of Dimes of Rhode Island, RI Department of Education, RI Dental Association, RI Parks and Recreation Association, American Academy of Pediatrics, RI Chapter, RI Indian Council, Progreso Latino, Initiatives for Human Development, Mayor's Council on Drug and Alcohol Abuse, RI Council on Alcoholism and Other Drug Dependence, The Carriage House, Socio-Economic Development Center for Southeast Asians, Rhode Island Cancer Council, University of Rhode Island, Cancer Prevention Center, Rhode Island Hospital, Roger Williams Hospital, RI Parent Teacher Association, Miriam Hospital, Veteran's Medical Center, National Association for the Advancement of Colored People
14. Radon	U.S. Environmental Protection Agency, Rhode Island Building Code Commission, American Lung Association of Rhode Island, Rhode Island Association of Builders, Rhode Island Realtors Association, Brown University, Center for Environmental Studies, University of Rhode Island, Geology Department
15. Drinking Water Quality	Public Water system owners/operators, Rhode Island Water Works Association, United States Environmental Protection Environmental Protection Agency (EPA), Municipal Governments, RI Department of Environmental Management, RI Water Resources Board, RI Public Utilities Commission, Clean Water Finance Agency
16. Fooodborne Pathogens	Rhode Island Food Safety Coalition, Hospitality Association, Food Dealers Association, Health Care Facility Associations, Elderly and Minority Organizations, University of Rhode Island, Rhode Island Department of Education, Johnson and Wales University

Health Objectives	Community Review and Comment Participants
17. Oral Health	*Healthy Schools! Healthy Kids!* Oral Health Steering Committee, RI Dental Association, RI Dental Hygienists Association, RI Health Center Association, St. Joseph Hospital for Specialty Care, RI Hospital, Samuels Dental Center, RI Department of Human Services, RI Department of Education, RI Department of Corrections, School Districts Statewide, Federal Bureau of Primary Health Care (BPHC)**BPHC-Supported Programs & Community Agencies Serving Underserved and Vulnerable Populations, A Variety of Internal HEALTH Programs and Initiatives
18. Birth Outcomes	Community Health Centers, Maternity Hospitals, RI Chapter, Healthy Mothers, Healthy Babies Coalition, RI Chapter March of Dimes, Project ASSIST, RIte Care, Health Plans, Drug and Alcohol Treatment Programs, Home Health Agencies, Community Literacy Programs, Community Social Service Agencies
19. High Blood Pressure	American Heart Association, NE Affiliate, RI Chapter; Diabetes Foundation of Rhode Island; RI Primary Care Physician Advisory Committee; Rhode Island Prevention Coalition; RI Department of Health Office of Minority Health; Memorial Hospital of RI
20. Breast & Cervical Cancer Screening	Hospitals, Private Health Care Providers, Radiological and Lab Facilities, Social Service Agencies, Community Health Centers, Medical Professional Organizations, Legislature, State Agencies, Senior Services, YWCA, Colleges & Universities, American Cancer Society, American Association of Retired Persons
21. HIV Prevalence	Division of Substance Abuse and Department of Mental Health, Retardation and Hospitals

Health Objectives	Community Review and Comment Participants
22. Infectious Diseases	Roger Williams Medical Center TB Clinic, TB Advisory Committee, Emerging Pathogens Advisory Committee, Community-Based Home Health Agencies, Hasbro Children's Hospital, Infection Control Practitioners, Centers for Disease Control and Prevention, University of Rhode Island Center for Vector-borne Disease, Rhode Island physicians/hospitals/laboratories, School nurse-teachers, South County Hospital, University of Rhode Island, Department of Environmental Management, RI Veterinary Medical Association, City/town animal control officers, animal shelters, and the Department of Environmental Management
23. Immunization	Immunization Action Coalition, School Nurse Teachers, Health Care Insurers, Health Care Providers, Community Health Centers, School Administrators, Day Care and Pre-Schools, Managed Care Organizations, RI Chapter, American Academy of Pediatrics, WIC Sites, Hasbro Children's Hospital, St. Joseph's Hospital for Specialty Care, Travelers Aid, Rotary International, March of Dimes, American Academy of Family Practitioners, RI Chapter, Minority Health Coalition
24. Primary Care	The RI Health Center Association, Primary Care Physician Advisory Committee, Practicing Primary Care Clinicians, RI Department of Human Services, RI Department of Education, RI Department of Corrections, Brown University School of Medicine, University of RI, College of Nursing, RI Medical Society & Other Health Professional Organizations, Federal Bureau of Primary Health Care (BPHC), BPHC-Supported Programs & Community Agencies Serving Underserved and Vulnerable Populations, A Variety of Internal HEALTH Programs and Initiatives
25. Activity Limitations	State and community-based organizations providing services to people with disabilities and their families, Brown University Population Studies and Training Center, Primary Health Care Providers, Centers for Disease Control and Prevention

Appendix A, Contributors 3
Director's Office Core Staff Contributors

Sections/Tasks	Contributors
Layout and Design	Richard Bolig
Minority Health Statistics	Jay Buechner, Ph.D.
Overall Quantitative Measurement of Progress	Jana Hesser, Ph.D.
Production Coordination	Michelle Santos
Minority Health Programs	Pheamo Witcher

Appendix B

Background and Methods for Healthy Rhode Islanders Indicator Data Update

- There are 25 main objectives; most have two or more sub-objectives. Complete or partial update data were available for 21 of the 25 main objectives.

- Baseline and update data are not available for the same years for all objectives, because the different data sources used are available for different years. Some are available annually, some biennially, and some every five years.

- Update measures have been converted to a standard index to indicate the magnitude of change for each objective on a scale from -100 to +100. The index is calculated as follows: (Present - Baseline/Target - Baseline) x 100. A score of "0" indicates no progress; a negative score indicates movement away from the target; a positive score represents improvement. A score of "100" indicates achievement or surpassing of the target objective. Improvements beyond 100% of the target are scored as 100%. The index for those objectives with two or more sub-objectives has been calculated as the average of all sub-objective indices. Weights have been applied to sub-objective indices only when noted.

- Mortality rates for Objectives 4,6,8,10,11, and 17 have been age adjusted using the 1940 United States population as standard, as in Healthy Rhode Islanders 2000.

- Baseline and target numbers are those originally presented in the publication Healthy Rhode Islanders 2000 (1993) unless noted otherwise. That document should be referred to for a complete definition of each objective and sub-objective.

- Update numbers are based on the most recently available data. Data from the same source has been used to derive baseline, update, and target numbers unless noted otherwise. Data sources are indicated.

- Update data were not available (NA) for several of the objectives, as indicated.

Appendix C: Health Objectives Indicator Data Update[1]

Objective	Index	Definition	Baseline	Baseline Year	Mid-course	Midcourse Year	Final Update	Final Update Year	Target	Data Source
1-Physical activity	-14	% 18+ with regular moderate exercise =>20 minutes/day	45	1991	46.7	1994	43.1	1998	60	BRFSS
		% 18+ with no regular exercise	28	1991	27.2	1994	29.9	1998	15	BRFSS
2-Healthy diet	6	%18+ eat 5+ servings fruits & vegs daily	29[2]	1989	22.4	1994	24.6	1998	60	BRFSS
		% with dietary fat 30% of calories, and saturated fat 10% of calories	NA[3]						60	NA
		% 18+ with serum cholesterol $\leq$ 200 mg/dL	NA[3]						100	NA
3-Tobacco use	21[4]	% Smokers age 20+	25	1991	21.8	1994	22.2	1999	15	BRFSS
		% Smokers age 18-24	23	1991	28	1994	28.3	1999	15	BRFSS
		% Smokeless tobacco use, males 12 -18	2.1 (ASAS)	1991 (grades 7-12)	6.6 (ASAS)	1995 (grades 7-12)	10.4 (YRBS)	1997 (grades 9-12)	0.5	ASAS YRBS
4-Alcohol &	-31	Drug related deaths/100,000	5.8	1988	5.8	1992	5.2	1997	4.6	VR
drug related										
problems[5]		Alcohol related motor vehicle deaths/100,000	5.6	1985-1990	3.7	1991-1993	3.3	1996	4.5	FARS
		% Adolescent alcohol use past month, grades 7 -12	45.9	1991	50	1995	39.6	1998	36.7	ASAS
		% Adolescent marijuana use past month, grades 7 -12	9.4	1991	20	1995	19.9	1998	7.5	ASAS

[1]See Appendix B for background and methodology.
[2]1989 data based on a Department of Health nutrition survey, modeled on the BRFSS but which used different questions to assess fruit and vegetable consumption. 1994 and 1998 data from the BRFSS were used to calculate the index.
[3]NA = Not available
[4] Sub-objectives weighted in calculating index, based on proportion of population included in each sub-objective.
[5] Targets for use are 20% less than baseline.

Objective	Index	Definition	Baseline	Baseline Year	Mid-course	Midcourse Year	Final Update	Final Update Year	Target	Data Source
		% Adult chronic drinkers	5.1	1990	4.7	1993	4.2	1999	4.1	BRFSS
		% Adult binge drinkers	17.8	1990	18.6	1993	15.4	1999	14.2	BRFSS
5-Unintended	33	Unintended pregnancies per 1000	35.5	1989	35.5	1991	32	1996	25	VR
pregnancies		pregnancies								
6-Suicide and suicide attempts	73	Suicides per 100,000	10.2	1984-1988	9.8	1989-1992	9.1	1993 -97	9.2	VR
		Self inflicted injury hospitalizations/100,000	70[6]	average 1988, 1990	53	1994	65.4	1998	60[6]	HDD
7-Mental disorders	NA	% Ages 0 -17 with mental disorders	11.5	1989	NA		NA		10	NA
		% 18+ with mental disorders	12.6	1984	NA		NA		10.7	NA
8-Homicides & assault injuries	82	Homicides/100,000	5.0[7]	1987-1989	3.2	1992-1994	3.1	1997	2	VR
		Assault injury hospitalizations/100,000	41[6]	average 1988, 1990	35	1994	25.5	1998	37[6]	HDD

[6]Figures revised due to improvements in hospital discharge data coding
[7]Baseline and target changed from original, due to expansion of baseline data from single year data to three years of data.

Objective	Index	Definition	Baseline	Baseline Year	Mid-course	Midcourse Year	Final Update	Final Update Year	Target	Data Source
9-Quality school	8	Health education as separate course required in schools,% of schools	58	1995	NA		88	1996	70	SHEP
health										
education[8]		Health education as a graduation requirement,% of schools	45	1995	NA		59	1996	60	SHEP
		Student required to repeat health education course if failed, % of schools	28	1995	NA		23	1996	40	SHEP
		Schools and districts support in-service training or staff development in health education,% of schools	97	1995	NA		91	1996	98	SHEP
		Health educators are certified or endorsed to teach health education	98	1995	NA		100	1996	98	SHEP
		Instructors have had major emphasis in health education in professional preparation, % of schools	20	1995	NA		16	1996	50	SHEP
10-Uninten-tional	6	Fatal unintentional injuries/100,000	26.5	1984-1988	19.6	1989-1992	16.0	1993-1997	22.5	VR
injuries										
		Unintentional injury hospitalizations/100,000	720[9]	average 1988, 1990	646	1994	764	1998	612[9]	HDD
11-Work-related injuries	48	Work related deaths/100,000 workers	3	1988	3.3	1993	3.1	1998	2.25	OSHA
		Work related injuries/100 workers	8.9	1990	7.5	1993	6.5	1998	6.7	OSHA
		Work related illnesses/100 workers	0.4	1990	0.4	1993	0.2	1998	0.3	OSHA
Objective	Index	Definition	Baseline	Baseline Year	Mid-course	Midcourse Year	Final Update	Final Update Year	Target	Data Source

[8]Indicators added in 1995.

[9]Figures revised due to improvements in hospital discharge data coding.

12-Children's blood lead	100	Percent of children 0-5 screened with blood lead >10µg/dL	46	1992	22.4	1994	9.5	1999	23	LSP
levels										
		Percent of children 0-5 screened with	8.2	1992	4.5	1994	1.3	1999	2	LSP
		blood lead >20µg/dL								
13-Environ-mental	45	% Children exposed to environmental tobacco smoke in enclosed spaces	24[10]	1992	27[13]	1994	25.2	1998	12	BRFSS
tobacco										
smoke		% Places that are smoke free	26	1992	62	1995	NA		50	OHRA
14-Radon	NA	%Occupied buildings with radon >4pCi/L	23	1992	23	1994	NA		11.5	OORH
15-Drinking	100	Proportion of population with drinking	60	1992	81	1994	99	1999	85	ODWQ
water		water meeting safe drinking standards								
		for entire year								
16-Foodborne pathogens	100	Incidence of Salmonella/100,000	31.6	1990	24.8	1994	16	1998	16	OFP
17-Oral health	53	% With dental visits in past year	68 (All Ages)	1990 (HIS)	69.5 (adults only)	1995 (BRFSS)	74.3 (adults only)	1999 (BRFSS)	85	HIS, BRFSS
		% Insured for dental care	52.7 (All ages)	1990 (HIS)	58.4 - adults only	1995 (BRFSS)	61.3	1996 (HIS)	90	HIS, BRFSS
		Mortality due to cancer of pharnyx & oral cavity ages 45-74/100,000	19	1968-1987	7.9	1988-1992	6.3	1993 -1997	7	VR
		% children ages 6-8 with caries	NA		NA		NA		35	NA
		% children ages 15 with caries	NA		NA		NA		60	NA

[10]Children in homes with parents who smoke

Objective	Index	Definition	Baseline	Baseline Year	Mid-course	Midcourse Year	Final Update	Final Update Year	Target	Data Source
18-Poor birth outcomes	50	Infant mortality/1000 live births	8.4	1991	5.7	1994	6.4	1993 -1997	6.5	VR
		% Low birth weight	6.2	1989	5.9	1991	6.8	1993 - 1997	5	VR
		% Tobacco use by pregnant women	23	1989	NA		NA		10	NA
		% Alcohol use by pregnant women	6	1989	NA		NA		5	NA
		% Drug use by pregnant women	6-10	1989-1991	NA		NA		5	NA
		% With prenatal care in 1st trimester	82.3	1989	86	1991	90.2	1998	90	VR
19-Reduce high blood pressure	NA	% of those with high BP who have it under control	NA		NA		NA		75	NA
20-Breast & cervical cancer screening	68	% 40 + ever breast and mammogram	76	1991	77.2	1994	80.5	1999	90	BRFSS
		% 50 + breast exam and mammogram in past 2 years	61.3	1991	61.2	1994	72.8	1999	80	BRFSS
		%18 + ever had pap	74	1991	89.5	1994	92.5	1999	95	BRFSS
		%18+ had pap in past 1-3 years	NA		80.6	1994	85.4	1999	95	BRFSS
21-HIV prevalence	100	Contain prevalence/100,000	89	1991	214	1995	187	1998	400	DDPC

Objective	Index	Definition	Baseline	Baseline Year	Mid-course	Midcourse Year	Final Update	Final Update Year	Target	Data Source
22-Infectious	-240[11]	TB incidence/100,000	7	1993	5.6	1994	6.4	1998	3.5	DDPC
diseases										
		Cats have rabies shot	83	1994	NA		NA		90	BRFSS
		Dogs have rabies shot	96	1994	NA		NA		99	BRFSS
		Lyme Disease incidence/100,000	30	1992	34.4	1995	79.8	1998	20	DDPC
23-Immuni-zation	79	% With basic series for children <2	62	1991	68.6	1994	84	1998	90	IP
24-Primary care	20	% With specific source of primary care	85	1990	NA		87	1996	95	HIS
		% with access to screening, counseling, and immunizations services	NA		NA		NA		100	NA
25-Activity limitations	-107	Proportion of people who experience major activity limitation	11.5	1985	NA		13.1	1996	10	HIS
		% Disabled persons with access to services and physical environment	NA		NA		NA		NA	NA
Overall Index	**27**									

[11] The index is heavily affected by the increase in Lyme disease incidence which may be the result of improvements in diagnosis rather than actual increase in the occurrence of the disease.

HEALTHY RHODE ISLANDERS 2000: HEALTH OBJECTIVES INDICATOR DATA UPDATE

DATA SOURCES:

BRFSS -- Behavioral Risk Factor Surveillance System
ASAS -- Adolescent Substance Abuse Survey
VR -- Vital Records
FARS -- Fatal Accident Reporting System
HDD -- Hospital Discharge Data
DDPC -- Division of Disease Prevention and Control
HIS -- Health Interview Survey
SHEP -- School Health Education Profile
OSHA -- Occupational Safety and Health Administration
OORH -- Office of Occupational and Radiological Health
ODWQ -- Office of Drinking Water Quality
OHRA -- Office of Health Risk Assessment
OFP -- Office of Food Protection
LSP -- Lead Screening Program
IP -- Immunization Program

Previously in this Series

Healthy Rhode Islanders 2000	January 1994
Healthy Rhode Islanders 2000: Mid-Course Review	June 1996

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